Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
Preswylfa Dental Practice
Activity date: 28 July 2021

Publication date: 15 September 2022

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Digital ISBN 978-1-80195-948-3

Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Preswylfa Dental Practice, Llangefni, Anglesey, as part of its programme of assurance work. Preswylfa Dental Practice provides private and NHS services, for patients of all age groups, within the area served by Betsi Cadwaladr University Health Board.

HIW's quality checks form part of a new tailored approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Private Dentistry (Wales) Regulations 2017. Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks are a snapshot of the standards of care within healthcare services. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us to provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to assurance and inspections can be found here.

We spoke to the principal dentist, who is also the responsible Individual[1] and registered manager[2] for the practice, on Wednesday 28 July 2021, who provided us with information and evidence about their service. We used the following key lines of enquiry:

- What changes have been implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How is the service ensuring that all patients (including vulnerable/at risk groups) are able to access services appropriately and safely?
- How has the practice and the services it provides adapted during this period of COVID-19?

[1] 'responsible individual' means an individual who is the director, manager, secretary or other officer of the organisation and is responsible for supervising the management of a private dental practice (Private Dentistry regulations 2017).
[2] 'registered manager' means a person who is registered under Part 2 of the Private Dentistry (Wales) Regulations 2017 as the manager of a private dental practice.

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- The most recent general environmental risk assessment
- COVID-19 specific environmental risk assessment

We also questioned the service representatives on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

The registered manager told us that they actively monitor the practice environment on a daily basis to ensure the environment is safe, clean and clutter free.

We were told that the front door of the practice is locked at all times to prevent members of the public from entering unattended and without an appointment. We were told that appropriate notices and signs are on display at the practice. We were told that patients who need to attend the practice are screened for symptoms of COVID-19 when they book their appointments so that they are aware of what symptoms would prevent them being allowed into the practice. They are also screened on the day of their appointment.

We were told that all five surgeries are accessed from corridors or stairways leading from the main entrance. However, two surgeries have fire exits that enable patients to exit though a different door at the rear of the building thereby reducing the risk of one patient coming into contact with another patient. We were told that all the surgeries are spacious, thus allowing for social distancing. We were also told that care is taken to limit the number of patients attending at the same time and that staff admitting patients onto the premises wear appropriate personal protective equipment (PPE).

The following areas for improvement were identified:

We were provided with a copy of the general risk assessment which was undertaken on 23 September 2019, and was due for review in September 2020. The registered manager noted on the self-assessment form that, as a result of this Quality Check, the environmental risk assessment will be reviewed as soon as possible. The registered manager must undertake a general risk assessment of the practice without further delay and provide HIW with a copy of the report.

The registered manager told us that the emergency equipment and oxygen are checked by

one of the dentists and a dental nurse on a monthly basis. However, the Resuscitation Council UK guidelines stipulate that emergency equipment should be checked on a weekly basis. The registered manager must ensure that the emergency equipment is checked on a weekly basis in line with the Resuscitation Council UK guidelines.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- COVID-19 policy
- COVID-19 risk assessment
- Environmental cleaning policy
- Standard Operating Procedure for provision of aerosol generating procedures on non COVID-19 patients
- The most recent decontamination audit
- End of day surgery closing down/cleaning schedules
- Decontamination room closing down/cleaning schedule
- Records of daily checks of autoclaves
- Dental instruments manual cleaning procedure

The following positive evidence was received:

The registered manager confirmed that all staff have a clear understanding of the latest Standard Operating Procedure[3] for the dental management of non COVID-19 patients. The guidance is intended for use by all dental care settings in Wales. Changes to the Standard Operating Procedure were communicated to staff by means of on-line meetings initially and more recently through face to face discussions.

The registered manager confirmed that staff have received regular COVID-19 updates. Any new guidance and procedures are discussed with staff, either during the monthly staff meetings or more frequently during daily discussions, to ensure that they understand the implications of the changes on their work.

We saw evidence that the practice had developed their own policies for the safe management of Aerosol Generating Procedures (AGP) which have been developed in line with the latest Standard Operating Procedure guidance.

[3] https://gov.wales/dental-management-non-covid-19-patients

The registered manager told us that staff have received various internal training sessions that included include infection prevention and control and the correct use of PPE i.e the donning, doffing and safe disposal of used equipment.

We were told that the use of general PPE equipment has been optimised with adequate stocks sourced. The registered manager did not foresee any issues with sourcing general PPE equipment in the future.

We saw evidence to show that the autoclaves[4] are being checked on a daily basis to ensure that they are working correctly.

The registered manager told us that they have not, to date, had to provide treatment to patients displaying COVID-19 symptoms or awaiting a COVID-19 test result and should the need arise, such patients would be seen at the end of the working day.

The following areas for improvement were identified:

We saw that a combined infection control and decontamination audit had been conducted using the Health Technical Memorandum (HTM) 01-05 audit tool, which is designed for use in England. The audit tool had not been fully completed and did not contain the name of the person undertaking the audit, the date when the audit was undertaken nor did it contain an action plan detailing how areas for improvement are to be addressed. The registered person must provide HIW with a copy of a fully completed decontamination audit tool, which should be signed and dated by the person undertaking the audit. It is recommended that the Welsh Health Technical Memorandum (WHTM[5]) 01-05 tool be used in future, in order to ensure compliance with the standards applicable to dental practices operating in Wales.

We were told that instruments are cleaned manually and that no automated cleaning takes place at the practice. It was therefore a concern that the infection control and decontamination audit highlighted that instruments are not routinely kept moist whilst awaiting manual cleaning. Additionally, we were told that instruments are not always checked, preferably using an illuminated magnifying glass, following manual cleaning. In addition, the registered manager informed us that there isn't any system in place to identify when unused instruments require re-processing in line with WHTM 01-05 guidance. The registered manager must ensure that instrument cleaning process reflects Chapter 3 of the WHTM 01-05 guidance.

We were provided with a copy of the practice's environmental cleaning policy, COVID-19 policy and Standard Operating Procedure which reflect the local protocol for cleaning of

[4] Autoclaves are items of equipment that are used in dental practices to sterilize all of the instruments and all of the materials used in professional procedures.
[5] WHTM 01-05 includes information on an audit of compliance with decontamination. The audit has been developed by dentists in Wales and is supported by the dental section, Health Education and Improvement Wales (HEIW). The audit is administered through the Clinical Audit Peer Review process and is now available to all general dental services (GDS) and Community Dental Service (CDS) dental teams in Wales.

surfaces and rooms used for clinical and decontamination processes. We noted that the environmental cleaning policy states that surgery floors should be mopped at the end of the day. This is not reflective of practice's COVID-19 policy and Standard Operating Procedure or the Chief Dental Officer's Standard Operating Procedure for the Dental Management of non-COVID-19 Patients in Wales[6] which specify that floors should be mopped at the end of a session and after each COVID-19 AGP. In addition, the COVID-19 policy refers to HTM 01-05 guidance rather than WHTM 01-05 guidance. The registered manager must ensure that the environmental cleaning policy reflects the requirements of the practice's COVID-19 policy and Standard Operating Procedure, the Chief Dental Officer's Standard Operating Procedure and the WHTM 01-05 guidance.

As previously mentioned, we were provided with copies of the end of day surgery and decontamination closing down/cleaning schedules. However, we were not provided with any cleaning schedules for non-clinical areas of the practice such as the reception, waiting rooms, toilets etc. The registered manager must provide HIW with copies of cleaning schedules covering the non-clinical areas of the practice.

The registered manager told us that they had experienced difficulty in sourcing suitable Filtering Face Piece 3 (FFP3)[7] face masks and that three members of staff had failed the fit test. The registered manager added that there are currently nine staff members who have been successfully fit tested to ensure the masks fit properly and offer adequate protection. The registered manager must continue with their efforts to source suitable FFP3 face masks and ensure that all staff who are required to use these masks have been properly fit tested.

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored whether management arrangements ensure that staff are suitable in their roles and are appropriately trained in order to provide safe and effective care.

The key documents we reviewed included:

- Statement of purpose
- Patient information leaflet
- Staff mandatory training
- Record card audit
- Ionising Radiation (Medical Exposure) Regulations (IRMER) audit

[6] https://www.gdc-uk.org/docs/default-source/covid-19/2020-12-17---sop-wales-covid19-final-version---17.12.20731fafd2-8a98-4cae-9a11-a1d13c79786f.pdf?sfvrsn=c0ae9266_3
[7] FFP3 respirators are designed to protect the wearer from breathing in small airborne particles which might contain viruses.

- A copy of the most recent annual report prepared by the registered manager
- Business continuity and disaster recovery plan

The following positive evidence was received:

The practice provides services to a high number of Welsh speaking patients and it is poitive to note that the majority of the staff are Welsh speaking. We were told that bilingual (Welsh/English) information for patients in the form of leaflets and posters are available within the practice. We were provided with a copy of the statement of purpose and patient information leaflet which contain relevant information about the services being offered. We were told that these documents are also available in Welsh and English.

We were told that the practice has an equality and diversity policy in place which set out the approach to equality, discrimination, diversity and human rights as it applies to both patients and staff. The registered manager told us that two staff members have undertaken equality and diversity training.

The registered manager confirmed that they were aware of incident reporting processes and knew how to contact HIW and the health board to report incidents.

We were told that there are no current staff on sickness absence and the practice does not have any current staff vacancies. We were also told that agency staff are not used.

The registered manager told us that they are a very small staff group who have provided mutual support to each other throughout the pandemic. Staff can also access more formal support through Denplan[8].

The following areas for improvement were identified:

We found that a number of the policies and procedures presented as supporting evidence for this quality check were not dated and signed. The registered manager should ensure that all such documents contain implementation and review dates and that they are signed by the author/reviewer. This will ensure that documents are version controlled and that there is an audit trail in place.

We were told that staff training was on-going through remote e-learning and some in-house face to face provision. We saw evidence of staff mandatory training records which showed that four staff members had not undertaken any mandatory training. The registered manager told us that these staff had been recently employed and were having difficulty accessing the e-learning training portal. The registered manager must ensure that all staff undertake training in mandatory subjects including Cardiopulmonary Resuscitation. Where staff are unable to access the e-learning training portal, other arrangements must be made to ensure that staff training is completed.

[8] https://www.denplan.co.uk/

The registered manager told us that annual staff appraisals had not been conducted for a couple of years. This means there was no formal monitoring of the competency of staff, the quality of the care that they provided to patients, or of individual development needs. The registered manager explained that they are a small team and that they regularly meet informally to discuss issues. The registered manager must ensure that appraisals are undertaken annually and a record kept on individual staff files.

Prior to the quality check, and as part of the practice's self-assessment, we requested a copy of the practice's consent policy. This was not provided. The register manager must provide HIW with a copy of the practice's consent policy.

The registered manager told us that any complaints or concerns about the service would be referred to them for resolution in line with the practice's complaints procedure. We were provided with copies of the practice's statement of purpose and patient information leaflet, both of which contained information about how to make a complaint. However, neither contained details of the NHS Wales Putting Things Right[9] process. However, the registered manger did inform us that there were both leaflets and posters relating to this within the practice. The registered manger should review and amend both the statement of purpose and patient information leaflet to include details of the Putting Things Right process.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the areas for improvements identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the quality check.

As a result of the findings from this quality check, the service should:

[9] Putting Things Right is a process for dealing with Complaints, Claims and Incidents which are collectively termed "Concerns". This represents a significant culture change for the NHS in Wales in the way in which it deals with things that go wrong, introducing a single and consistent method for grading and investigating concerns, as well as more openness and involvement of the person raising the concern.

- Ensure that the areas for improvements are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.