Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

General Dental Practice Inspection (announced)

Cwm Taf University Health Board, Tonyrefail Dental Centre

11 November 2014

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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 978-1-4734-2774-7

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1. Introduction

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Tonyrefail Dental Centre at 2 Pritchard Street, Tonyrefail, CF39 8PA within the area served by Cwm Taf University Health Board on 11 November 2014.

During the inspection we considered and reviewed the following areas:

- Patient experience
- Delivery of Standards for Health Services in Wales
- Management and leadership
- Quality of environment

2. Methodology

HIW inspections of General Dental Practices seek to establish how well practices meet the standards in *Doing Well, Doing Better: Standards for Health Services in Wales*[1].

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

- Information held by Healthcare Inspectorate Wales (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
- HIW questionnaires completed by patients
- Examination of equipment and premises

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[1] Doing Well, Doing Better: Standards for Health Services in Wales came into force from 1st April 2010. The framework of standards sets out the requirements of what is expected of all health services in all settings in Wales. www.weds.wales.nhs.uk/opendoc/214438

- Information within the practice information leaflet and website (where applicable)

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 will be 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.

3. Context

Tonyrefail Dental Centre provides services to patients in Tonyrefail. The practice forms part of dental services provided within the geographical area known as Cwm Taf University Health Board. The practice employs a staff team which includes one dentist; one receptionist/practice support, one dental nurse and a practice manager (who also manages another IDH dental practice within Cwm Taf).

A range of services are provided. These include:

- Diagnostic and screening procedures
- Oral health check-ups
- Treatment of disease
- Emergency dentistry
- Children's dentistry
- Private dentistry

4. Summary

HIW explored how Tonyrefail Dental Centre meets the standards of care in the Doing Well, Doing Better: Standards for Health Services in Wales.

The former dental practice was dissolved four years ago at a point when the business was purchased by Integrated Dental Holdings (IDH). IDH has retained overall responsibility for the operation of the dental centre at 2 Pritchard Street, Tonyrefail, CF39 8PA since that time.

The following points relate to what people indicated within completed HIW questionnaires and what we found at this inspection:

- Our observations on the day of inspection and patient responses within completed HIW questionnaires indicated that patients were treated with kindness and compassion
- Overall, we found that patients' treatment was planned and delivered in a way that was intended to ensure their safety and welfare
- Members of the dental team were clear about their respective roles and responsibilities. In addition, team members were provided with the opportunity to learn and develop
- Overall, patients can be assured that the dental team make every effort to ensure that the dental centre environment is safe and their privacy is protected

We also found that there were several aspects of the service which needed to be improved. These were:

- The dental service provider is required to provide HIW with specific detail as to how, and when, improvements are to be made to the environmental arrangements in place regarding the cleaning, separation and disinfection of instruments at the dental centre
- The dental service provider is required to provide HIW with a full description of the on-going monitoring and quality assurance/clinical governance arrangements in place at the dental centre
- The dental service provider is required to demonstrate how it will ensure that all staff are supervised and supported in the delivery of their role. This is in accordance with current Standards for Health Services in Wales

- The dental service provider is required to demonstrate how it will ensure that staff implement a complaints procedure which is fully compatible with the NHS Wales ‘Putting Things Right’ arrangements in the future
- The dental service provider is required to provide HIW with detailed information regarding the proposed refurbishment plan for the dental centre. This is in order to demonstrate compliance with Standards for Health Services in Wales

5. Findings

Patient Experience

Our observations on the day of inspection and patient responses within completed HIW questionnaires indicated that patients were treated with kindness and compassion.

A total of 21 HIW patient questionnaires had been completed during the week prior to the announced inspection, each of which showed that the dental team always made them feel welcome when they visited the surgery. Approximately 50 per cent of the 21 patients had attended the surgery regularly for more than 20 years. Two patients provided us with the following written comments:

'Surgery always warm and inviting. Telephone manner good'

And

'Really pleasant Practice and staff are very friendly'

In addition, we directly observed the kind and friendly approach adopted by members of the staff team when speaking with patients on a face to face basis, or via the telephone.

Six completed patient questionnaires indicated that people had experienced a delay in being seen by the dentist on the day of their appointment, two of whom provided additional comments stating that such delays had been occasional.

A conversation held with practice support staff revealed that emergency appointments were provided in response to individual needs; every effort being made to see people on the day they made contact with the dental centre. Where that was not possible, a suitable alternative date would be offered. We were able to confirm those arrangements during the inspection at the point when an individual visited the practice with dental pain.

A question regarding whether patients felt they were given sufficient information about their treatment options, led to positive comments/responses within completed questionnaires. A sample of those comments is shown below (as patients provided us with their agreement for their inclusion in this report):

'Yes, always explained'

'I've had numerous dentists over the years, but this one is the best by far'

And

'Very good dentist'

Seven patients indicated that they did not know how to access out of hours dental services and one person stated that they would use the internet to obtain such information. The remaining 14 patients showed that they were aware of how to obtain care and treatment out of hours if needed. We did observe that relevant contact numbers for out of hours dental services were displayed in a window close to the entrance of the building.

Conversation with the practice manager revealed that patients were provided with the opportunity to offer their views on services received at the dental centre. However, we were told that patients rarely completed the patient feedback forms available in the ground floor reception area.

We found that patients had access to a patient information leaflet, supplies of which were available in the reception area. The leaflet offered information about the ownership of the dental centre, the cost of NHS treatments and also referred to the availability of private treatment.

Of 21 patient questionnaire responses received, 10 demonstrated that people did not know how to raise concerns or make a complaint about their dental care. We also found that there were no posters displayed for patients to help them decide what to do if they had any concerns about their dental treatment. There was a small laminated poster high up on a wall in the ground floor waiting area which contained an NHS website address, but this may not be easily seen by some patients and not everyone has access to the internet in their daily lives. In addition, patients may not choose to communicate with the Health Board in that way. Further exploration of the arrangements in place at the dental centre regarding complaints handling resulted in a recommendation for improvement. The detail of that can be seen within the section of this report entitled 'Management and Leadership' and Appendix A.

Delivery of Standards for Health Services in Wales

Summary

Overall, we found that patients' treatment was planned and delivered in a way that was intended to ensure their safety and welfare

Discussions with the dentist revealed the efforts made to plan and deliver patient care and treatment in a way that was intended to ensure their safety and welfare. This was achieved in part, by checking patients' medical history at every visit to ensure that possible risks to their health were identified and recorded.

We selected and scrutinised a sample of eight dental records (i.e. five NHS patient records and three which related to completed private dental treatment). As a result, we found that patient care entries generally contained sufficient detail about their reason for attendance, symptoms, evidence of treatment planning, treatment options and individual consent. We also found that appropriate referrals had been made to other professionals such as orthodontic and maxillo-facial consultants, in direct response to patients' identified needs. Additionally we found that Basic Periodontal Examination (BPE[2]) scores had been recorded in relation to completed consultations with adults.

Examination of the sample of NHS patient records showed that the dental centre had arranged patient dental recall visits in accordance with the National Institute for Health and Care Excellence (NICE)[3] guidelines.

Patients' records were kept at the dental centre on a computer database. The only information generated in paper form related to new or updated medical histories. We were also assured that each member of staff had their own unique computer passwords and all information was 'backed up' on a regular basis to ensure that patient records were maintained on the system. We did however find that one of the filing cabinets in the reception area (which contained patient information), was unlocked. This was brought to the attention of the practice manager, who ensured that the cabinet was made secure.

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[2] The BPE is a dental screening tool that is used in relation to gum conditions.

[3] The NICE dental recall clinical guideline helps dentists to decide how often patients should be recalled between oral health reviews that are appropriate to the needs of individual patients. The recommendations apply to patients of all ages receiving primary care from NHS dental staff in England and Wales.

We found that the arrangements in place in relation to the use of x-ray equipment were in-keeping with existing standards and regulations. This included training updates for appropriate staff and regular audit (checking) activity associated with the quality of patients' dental x-rays.

The dental centre had adequate procedures in place to deal with emergencies; resuscitation equipment including an Automated External Defibrillator (AED) being available for use as recommended by the Resuscitation Council UK. Examination of three staff files showed that they had received medical emergency training in January 2014; a refresher session having been arranged for January 2015.

Emergency drugs were found to be securely stored together with the resuscitation equipment. We also found that there were suitable arrangements in place to ensure that expired drugs were promptly replaced and that there was always a member of staff working at the practice trained in the use of first aid. In addition, daily checks were in place to ensure that emergency equipment was ready for use.

Scrutiny of the procedures in place regarding cleaning and sterilisation of instruments (otherwise known as decontamination) revealed that improvement was needed to the process in place. Specifically, there was only one sink within the ground floor surgery designated for cleaning and rinsing instruments, the other sink being used exclusively for hand-washing. We also found that staff were required to transport instruments (which had been cleaned after patient use in the dental surgery room), to the kitchen area where the sterilizer was stored.

Transportation of instruments was undertaken through the use of a plastic box. This would then be placed on top of the steriliser as there was no work surface for staff to rest the plastic box whilst transferring instruments into the ultrasonic machine. Similarly, when the sterilization cycle was complete, staff would then use a 'clean' plastic box placed on top of the machine to enable them to remove the sterilised instruments. Instruments were then transported back into the dental surgery room for further use.

Specifically, we found that the absence of sufficient work space in the kitchen area, the placement of both 'dirty' and 'clean' instruments on top of the sterilizer and the combined use of the kitchen (for staff changing, x-ray development, food preparation/eating, food storage and storage of some dental items) increased the risk of cross contamination. In addition, there was no clear separation of dirty to clean workflow for cleaning and sterilising dental instruments.

Conversations held with the dentist and practice manager regarding the above issues revealed that the dental centre was due to be refurbished. However, telephone discussions with two senior IDH employees and scrutiny of the proposed refurbishment plan did not provide sufficient assurance that improvements would be made to the process of cleaning and decontamination of instruments as determined by Welsh Health Technical Memorandum (WHTM)[4] 01-05 guidelines. Additionally, discussions held about the future day to day operation of the service also failed to offer assurance that the dental provider had any plans in place to demonstrate a move to continual improvement of the dental centre towards the requirements of WHTM 01-05. Conversations with the dentist did however indicate that every effort was always made to ensure that dental instruments were adequately cleaned despite the challenges posed by the surgery environment; a full description of the cleaning process being provided.

Recommendation

The dental service provider is required to provide HIW with specific detail as to how, and when, improvements are to be made to the environmental arrangements in place regarding the cleaning, separation and disinfection of instruments at the dental centre.

The dental centre was observed to have appropriate bagged and dated instruments for use in one month.

We also saw that colour coded cleaning equipment (mops and buckets) was available, to prevent cross infection.

Scrutiny of maintenance records enabled us to confirm that the dental centre had an on-going contract in place to ensure the appropriate handling, storage and disposal of hazardous waste.

[4] Welsh Health Technical Memorandum (WHTM) 01-05 is intended to progressively raise the quality of decontamination work in primary care and dental services.

Management and Leadership

Overall, we found that members of the dental team were clear about their respective roles and responsibilities. In addition, team members were provided with the opportunity to learn and develop.

The former dental practice was dissolved four years ago at a point when the business was purchased by Integrated Dental Holdings (IDH). IDH has retained overall responsibility for the operation of the dental centre at 2 Pritchard Street, Tonyrefail, CF39 8PA since that time.

An experienced practice manager was responsible for the running of the dental centre together with another IDH operated dental facility within the Cwm Taf area. As a result, the day to day running of the service in Tonyrefail was mainly undertaken by a person in the role of receptionist/practice support; having been employed at the dental centre for almost thirty years.

Overall, we found that the service operated through the use of a range of established management systems and processes to ensure that patients' care and treatment was delivered safely and in a timely way.

However we were only able to confirm that audit activity regarding health and safety, decontamination of instruments had been completed during January and April 2014. No further checks had been undertaken. Neither was it clear as to whether all of the remedial action suggested by the former IDH compliance manager during the April 2014 visit, had been completed. Routine (quarterly) audits of infection control requirements are required in accordance with WHTM 01-05.

Recommendation

The dental service provider is required to provide HIW with a full description of the on-going monitoring and quality assurance/clinical governance arrangements in place at the dental centre.

The receptionist we spoke to told us that she felt supported in her work. She also told us that she attends staff meetings with the dentist and the practice manager every four weeks, with staff at another IDH dental practice. Such meetings were used to convey new/relevant information to the respective dental teams and to promote discussion regarding patient care and treatment. We did not look at any of the notes that had been recorded at those events.

We held a brief conversation with the dental nurse working on the day of inspection and discovered that she had been employed by IDH in recent months. She told us that she had since begun training toward a relevant dental

qualification and had been provided with an initial induction to enable her to become familiar with processes and procedures in the workplace. The practice manager did however indicate that the dental nurse usually worked at the other IDH dental surgery in the Cwm Taf area and was only providing temporary support to the dental centre in the absence of the trained dental nurse who normally worked there.

Conversation with the practice manager demonstrated that staff were able to discuss practice and performance issues with her on a regular basis. She also told us that staff were provided with an annual appraisal as a means of focussing on their performance for the past year and identifying training needs for the coming year. However, we found that the practice manager had not received an annual appraisal due to a change in the IDH area manager allocated to the dental centre.

Recommendation

The dental service provider is required to demonstrate how it will ensure that all staff are supervised and supported in the delivery of their role. This is in accordance with current Standards for Health Services in Wales.

We found that staff received appropriate support with regard to their on-going professional development; training being provided through a range of e-learning packages via the IDH Academy system together with opportunities to attend relevant learning sessions provided by external sources. We were also informed about the emphasis being placed on training staff in relation to safeguarding (adults and children).

Scrutiny of a range of written policies and procedures in place demonstrated that staff had easy access to current and relevant guidance with regard to safe working practises.

We found that the complaints (concerns) policy in place was consistent with 'Putting Things Right'[5]. However, the policy was not consistent with the dental

[5] In April 2011 the Welsh Government introduced new arrangements for the management of concerns: *Putting Things Right.* It aimed to make it easier for patients and carers to raise concerns; to be engaged and supported during the process; to be dealt with openly and honestly; and for bodies to demonstrate learning from when things went wrong or standards needed to improve. http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

centre's separate document entitled 'Code of Practice for Patient Complaints'. Specifically, the timescales for acknowledging complaints exceeded those prescribed within 'Putting Things Right'. In addition, we examined the detail of a complaint lodged with the dental centre in the past twelve months and found that the patient concerned had not received an acknowledgement of their complaint, or satisfactory resolution of the matter within required timescales. Neither were we provided with evidence of any correspondence which alerted the patient to any perceived delay in resolving the issue they had raised. We also found that there were no posters displayed within the waiting areas to provide patients with information as to how they could raise any concerns/complaints about their care or treatment. The practice manager did however make arrangements to obtain such posters on the day of inspection.

Recommendation

The dental service provider is required to demonstrate how it will ensure that staff implement a complaints procedure which is fully compatible with the 'Putting Things Right' arrangements in the future.

A sample of accident records was examined. One incident had occurred in the past twelve months concerning a member of staff. The accident book in use was compliant with the Data Protection Act.

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

Quality of Environment

Overall, patients can be assured that the dental team make every effort to ensure that the dental centre environment is safe and their privacy is protected.

Tonyrefail dental centre is an established practice. Car parking spaces were available along the main road where the practice was situated. Patients with mobility difficulties were able to access the practice building. This is because the main door of the premises was wheelchair accessible albeit that some patients may experience some difficulties moving their wheelchair over a slightly raised metal strip at the entrance. In addition, the one existing patient treatment room/surgery was situated on the ground floor.

During the inspection visit, we considered whether the clinical facilities available at the dental centre conformed to current standards for health services in Wales-as outlined in the document entitled Doing Well, Doing Better[6]. Our observations served to confirm that the facilities and equipment in the ground floor surgery were adequate, although work surfaces were cluttered due to the limited storage/cupboard space available. The dental service provider had recently purchased a new dental chair for the surgery. However, the remainder of the internal environment overall was considered to be inadequate and non-compliant with standard 12.

The dental centre reception was situated on the ground floor together with room for only one patient to sit and wait as the majority of the space was taken up by the reception desk and low level metal patients' records cabinets. The area behind the reception desk provided staff with very little space to work as there was nowhere else to store resuscitation equipment and filing cabinets. Lighting in that area was found to be dim.

A tour of the ground floor of the building revealed a kitchen and staff toilet beyond the one dental surgery in use. The kitchen was cramped and very cluttered throughout, paint was peeling away from the walls and the entire area appeared in need of cleaning. There was no available work surface for staff to use; all such areas being used to accommodate equipment associated with the

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[6] http://www.wales.nhs.uk/governance-emanual/standards-for-health-services-in-wales-s. The Standards for Health Services in Wales is underpinned by supporting guidance. Specific guidance on each individual standard (1 – 26) can be found within this document.

provision of dental care. Staff were also required to use the 'kitchen' to eat and drink at break-times and to change into their uniforms from their 'outside' clothing with no privacy, especially as the door between the kitchen and dental surgery contained a panel of clear glass. Lighting in the kitchen area was dim.

Recommendation

The dental service provider is required to provide HIW with detailed information regarding the proposed refurbishment plan for the dental centre. This is in order to demonstrate compliance with Standards for Health Services in Wales.

Observation of the first floor accommodation highlighted that the second dental surgery/treatment room had not been operational for some time; being used instead for storage purposes. The patient waiting area alongside that room was clean and contained chairs for approximately eight people. There was also a toilet for patients' use. However, whilst the toilet appeared clean and hygienic, the plastic waste bin contained a number of jagged edges which could cause injury to either patients or staff. This was brought to the attention of the practice manager who agreed to ensure that the bin was replaced.

The combined size of the waiting areas at the dental practice were appropriate for the number of dental surgeries in use at the time of our inspection. However, we were told that the first floor (unused) surgery was due to be refurbished to accommodate the work of a hygienist. It is therefore likely that the existing waiting areas may become inadequate at that stage.

Fire extinguishers held within the building were found to be secure and had been checked by the fire authority. In addition, we observed the display of notices within the building alerting patients and staff as to what they should do in the event of fire.

We also found that security precautions were in place to prevent unauthorised access to areas of the building not used by patients.

The name and qualifications of the dentist working at the centre together with an 'out of hours' contact number were clearly displayed on the exterior wall/window of the building to inform patients attending for treatment.

6. Next Steps

This inspection has resulted in the need for the dental practice to complete an improvement plan in respect of Tonyrefail Dental Centre. The details of this can be seen within Appendix A of this report.

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

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

Appendix A

General Dental Practice: Improvement Plan

Practice: Tonyrefail Dental Centre

Date of Inspection: 11 November 2014

Page Number	Recommendation	Practice Action	Responsible Officer	Timescale
	Patient Experience			
	None			
	Delivery of Standards for Health Services in Wales			
Page 10	The dental service provider is required to provide HIW with specific detail as to how, and when, improvements are to be made to the environmental arrangements in place regarding the cleaning, separation and disinfection of instruments at the dental centre.			
	Management and Leadership			

Page Number	Recommendation	Practice Action	Responsible Officer	Timescale
Page 11	The dental service provider is required to provide HIW with a full description of the on-going monitoring and quality assurance/clinical governance arrangements in place at the dental centre.			
Page 12	The dental service provider is required to demonstrate how it will ensure that all staff are supervised and supported in the delivery of their role. This is in accordance with current Standards for Health Services in Wales.			
Page 13	The dental service provider is required to demonstrate how it will ensure that staff implement a complaints procedure which is fully compatible with the NHS Wales 'Putting Things Right' arrangements in the future.			
	Quality of Environment			
Page 15	The dental service provider is required to provide HIW with detailed information			

Page Number	Recommendation	Practice Action	Responsible Officer	Timescale
	regarding the proposed refurbishment plan for the dental centre. This is in order to demonstrate compliance with Standards for Health Services in Wales.			

Practice Representative:

Name (print): .....

Title: .....

Signature: .....

Date: .....