Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Longford Road Dental Practice

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Longford Road Dental Practice as part of its programme of assurance work. The practice offers private and NHS services on the Isle of Anglesey, within Betsi Cadwaladr University Health Board. They have a team of five dentists and nine dental nurses, as well as two administrative staff.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards (2015), Private Dentistry (Wales) Regulations 2017 and other relevant regulations. 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 settings. 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 provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the registered manager on 16 March 2021 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- What changes have you implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How are you 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?

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients and staff. We reviewed recent risk assessments and incident reviews, and questioned the setting 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:

We saw evidence of an environmental risk assessment which included a section of risks specific to COVID-19. We were told that changes had been made to the environment as a result of the pandemic and that Personal Protective Equipment (PPE) and hand sanitizers were available in the clinic and cleaning schedules had been amended to enable more frequent cleaning. We were informed that all staff and patients were required to wear face mask and face shields were offered to those exempt from wearing masks.

We were told that social distancing measures had been put in place, with stickers on the floor to indicate two metres social distance. Only patients with pre-arranged appointments would visit the practice. We were told that furniture and seating had been removed from the waiting area to allow for social distancing and adequate cleaning. When patients arrived for appointments it was described to us that they were asked to wait in their cars or outside until a member of staff instructed them to enter. We were informed that a one way system was in place throughout the building, with patients told to enter through the front door of the premises and to leave through the back door.

We were told that COVID-19 risk assessments had been completed for all staff. Depending on the outcome of the assessment, the practice would determine if the staff member needed to shield[1]. At the start of the pandemic three members of staff were required to shield.

We were told that all five surgeries were equipped to perform Aerosol Generating Procedures (AGP)[2]. Extractor fans had been purchased for every surgery to facilitate the removal of contaminated air. Where possible patients requiring AGP treatments were given appointments towards the end of the day so that additional cleaning could be carried out with minimal disruptions to appointment times.

In order to allow for adequate disinfecting time between patients, a reduced amount of appointments were available. Staff stated that this had not had any impact on the patient experience or the care that patients received. The manager stated that they felt staff worked and adapted well within the restrictions and guidelines.

[1] This word is used to describe how people at high-risk should protect themselves by not leaving their homes and minimising all face-to-face contact.
[2] An aerosol generating procedure (AGP) is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route.

No improvements were identified.

Infection prevention and control

During the quality check, we considered how the practice has responded to the challenges presented by COVID-19. We considered how well the practice manages and controls the risk of infection to help keep patients and staff safe. We reviewed infection control policies, infection rates and risk assessments.

The following positive evidence was received:

We were provided with the policies and procedures in place for the prevention and control of infection, which included their COVID-19 guidance. We saw evidence of Infection Prevention and Control (IPC) audits, together with the proposed actions that had been undertaken within the last year to assess and manage the risk of infection.

We were told of the systems in place to ensure all staff were aware of, and discharged their responsibilities for preventing and controlling infection. This was evidenced in a Social Distancing Guidance policy setting out the actions and responsibilities of management and staff in order to prevent the spread of the virus. Additionally, we were told that PPE training, including mask training, had been delivered to all staff and there were practice sessions before the practice reopened to patients.

COVID-19 vaccinations had been arranged for staff through the local health board. We were told that all staff had received at least their first vaccination, with most having received both the doses required.

Staff explained that patients were contacted by telephone prior to their appointment and asked a series of questions to determine whether they were at risk of transmitting the virus. Patients who were displaying symptoms or were awaiting results of a COVID-19 test were instructed to stay home and not attend the practice. Vulnerable patients were seen in the morning where possible.

The practice stated they kept a month's stock of PPE. We were told that weekly stock checks were performed to ensure there was sufficient PPE and the stock checks were kept on file.

No improvements were identified.

Governance

As part of this standard, HIW explored whether management arrangements ensured that there were sufficient numbers of appropriately trained staff available to provide safe and effective

care.

We reviewed staffing and patient levels, staff training and absences, management structures, practice functions and capacity, incidents and a variety of policies.

The following positive evidence was received:

We saw evidence of training records, which showed compliance with mandatory training. Staff also explained the process for ensuring training was up to date. In the absence of face to face training, staff continued to use e-learning[3] packages for Continued Professional Development (CPD). We were told that Basic Life Support (BLS) training had been arranged and would be delivered in two sessions of small groups of staff to allow for social distancing.

Staff explained that during the initial stages of the pandemic the practice closed to patients for a period of three months. During this time staff continued to attend the practice to take calls for remote triage[4].

The practice had a process where incidents were recorded in a reporting book. We were told that staff were aware of their roles and responsibilities in reporting incidents to regulatory agencies including Healthcare Inspectorate Wales (HIW). Any updated guidance for healthcare professionals was delivered in regular staff meetings, via staff the social media group and emails.

The process of checking emergency equipment was explained where one clinical lead was responsible for performing the weekly checks and we were told this was recorded by signing and dating a log. All staff had been trained to perform these checks.

We reviewed the Statement of Purpose[5] and Patient Information Leaflet[6], which contained all required information.

No improvements were identified.

[3] Learning conducted via electronic media, typically on the internet.
[4] The assignment of degrees of urgency to decide the order of treatment of a number of patients.
[5] "statement of purpose" ("*datganiad o ddiben*") means the statement compiled in accordance with regulation 5(1) of the Private Dentistry (Wales) Regulations and Schedule 1.
[6] Information as required by Schedule 2 of the above regulations.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- 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 findings 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:

- Ensure that findings 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.

Improvement plan

Setting: Longford Road Dental Practice

Date of activity: 16 March 2021

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	No improvements were identified.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Name:

Date: