Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# General Dental Practice Inspection Report (Announced)

## NJS Dental practice

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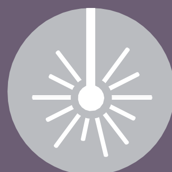

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# Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

## Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

## Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

## Our goal

To be a trusted voice which influences and drives improvement in healthcare

## Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

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# 1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced inspection of NJS Dental Practice on 8 October 2024.

Our team for the inspection comprised of a HIW healthcare inspector and a dental peer reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of five questionnaires were completed by patients or their carers and six were completed by staff. Due to the number of responses, only a limited amount of feedback has been included in this report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

# 2. Summary of inspection

## Quality of Patient Experience

Overall summary:
We found patients were treated with dignity and respect by staff operating in a courteous and professional manner. Patient comments were all complimentary of the staff and service they had received at NJS Dental.

The management of urgent care and cancellations were both suitable and we also saw reasonable adjustments in place to support staff and patients.

Appropriate arrangements were in place to enable effective communication between clinicians and patients, and we saw evidence that the equal treatment of both patients and staff were actively supported.

This is what the service did well:
- Varied health promotion information was available for patients
- Wait times for patients were managed effectively.

## Delivery of Safe and Effective Care

Overall summary:
We found the practice was in a good state of repair both externally and internally and was kept to a good standard to deliver safe and effective care to patients. We found some areas to improve in the decontamination room, including noise levels for staff and the storage of cleaning mops, which were resolved on the day of inspection. We also found some equipment required repair and some equipment testing was not taking place. However, we found that overall compliance with infection prevention and control procedures was satisfactory.

We saw arrangements in place for the management of medicines were appropriate and medical emergency equipment was also suitable. Staff records indicated that there was no trained first aider working at the practice, however, this was resolved during the inspection. We saw the process for the Control of Substances Hazardous to Health (COSHH) was satisfactory and fire safety arrangements were robust.

This is what we recommend the service can improve:
- The registered manager must ensure risk assessments are completed in line with the guidance available to them

- The registered manager must ensure equipment testing takes place routinely
- The registered manager must ensure complete patient records are kept at all times in line with General Dental Council (GDC) requirements and Faculty of General Dental Practice UK guidelines.

This is what the service did well:

- Staff had a clear understanding of their responsibilities while being aware of where to seek relevant professional advice, when needed
- The practice safeguarding procedures were robust.

## Quality of Management and Leadership

Overall summary:
We found clear management arrangements in place to enable the effective running of the practice. The staff we spoke with were engaging, knowledgeable and supportive of one another. Staff told us they had confidence in managers and would know who to speak to, if they needed help or support. We observed good staff working relationships and noted a positive working environment at the practice.

We saw quality improvement activities did take place but there were areas to improve in the expected activities the practice undertook. Patient feedback was routinely collected but we did not see a means to communicate any changes made as a result of feedback to patients.

Immediate assurances:

- We saw no evidence of reference checks having taken place on any staff member at NJS Dental. We also found half of the staff at the practice had either the incorrect level of Disclosure and Barring Service (DBS) checks or there were no records of checks having taken place. The registered manager must provide evidence to HIW that all mandatory pre-employment checks have taken place, and they must review their procedures to ensure these checks routinely take place.

This is what we recommend the service can improve:

- The registered manager should implement a means of communicating any changes made as a result of feedback to patients
- The registered manager must review their quality improvement policy to include all mandatory audits and commence the required audits without delay.

This is what the service did well:

- Individual staff members were completing relevant additional training above the mandatory expectations
- We observed strong working relationships between staff and noted a positive working environment at the practice.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

# 3. What we found

## Quality of Patient Experience

### Patient feedback

HIW issued a questionnaire to obtain patient views on the care provided at NJS Dental. In total, we received five responses from patients at this setting. Patient comments included:

> *"Excellent service."*
>
> *"The only dentist I trust."*
>
> *"Managed to make someone who was worried about visiting the dentist now a person who is completely happy to attend appointments!"*

### Person-centred

**Health promotion and patient information**
Suitable information was available at reception for patients, this included paediatric dental health, sepsis and dental care during pregnancy. The practice statement of purpose was available for patients to review upon request and the patient information leaflet was available at reception. We observed the fees for patients were clearly displayed alongside the names and General Dental Council (GDC) numbers of practitioners. We saw the opening hours and emergency contact details displayed on the front of the practice.

**Dignified and respectful care**
We found patients were provided with dignified and respectful care throughout their time at NJS Dental. We noted the reception and patient waiting area were joined, meaning interactions between patients and reception staff could be overheard. However, patients were given the option to speak with staff confidentially away from the reception area. Staff informed us that no private patient information was repeated over the telephone to protect patient privacy. A practice confidentiality agreement was in place, which outlined the expectations on staff to ensure the privacy of patient information.

The practice had solid surgery doors, which were kept closed during appointments. We noted the Nine Principles prepared by the GDC were on display at reception.

## Timely

### Timely care

We found appropriate arrangements in place to utilise the time of practitioners by managing appointments effectively. Patients could make appointments over the telephone or in person. Where appointments extended beyond their scheduled time, we were told that practitioners would telephone reception to explain to patients the reasons for delays. In the case of longer delays, patients were offered appointments at an alternative time or date.

Any patient in need of an emergency appointment was advised to telephone the practice. Patients were triaged over the telephone, with reception staff consulting the dentist where necessary. We were told that no patient would wait over 24 hours to be seen in the event of an emergency.

Staff told us the wait times for routine appointments were usually one week for existing patients or three for any new patients. Appointments were arranged in accordance with patient availability wherever possible, including arranging paediatric appointments outside of school time.

## Equitable

### Communication and language

We found suitable arrangements in place to enable effective communication between clinicians and patients. Staff told us documents would be made available in different formats for patients, upon request. Staff told us they used online translation tools, when necessary, to communicate with patients in their preferred language. Staff told us they recognised the importance of ensuring treatments were available in the preferred language of patients.

### Rights and equality

We saw evidence that the equal treatment of both patients and staff were actively supported, and the rights of individuals were suitably upheld. Appropriate policies outlined the practice approach to supporting the rights of patients and staff. We saw staff undertook specific training to protect the rights of patients, as well as the prevention of harassment or discrimination.

Staff provided examples where changes had been made to procedures or the environment as a reasonable adjustment for both patients and staff. These included the purchase of a specialist chair to support patients with mobility difficulties and a saddle chair for a member of staff.

The rights of patients were further upheld by allowing patients to choose their preferred pronouns and names on their records, with a note placed on file to ensure all staff were aware of these preferences.

# Delivery of Safe and Effective Care

## Safe

**Risk management**
We found the practice was in a good state of repair both externally and internally and was kept to a good standard to deliver safe and effective care to patients. The practice was suitably set over two floors, with surgeries on the ground floor and a staff only area upstairs. The reception area was appropriately sized to support the number of patients, and all areas were finished to a high standard. The lighting, heating, ventilation and signage were all satisfactory.

The practice suction equipment was kept inside two cabinets, in the decontamination room. This equipment produced noise which could be uncomfortable for staff working in this environment. Any staff member who wished to use the room for an extended period could come in to contact with a higher amount of noise at work than could be considered safe. Due to the potential impact on staff safety, these concerns were resolved during the inspection. Further information on the actions taken by the service in respect of this matter are outlined in Appendix A.

We heard telephone lines working effectively. There were clean and suitably equipped toilets for staff and patients, including a ground floor toilet for those with accessibility requirements. We saw suitable staff changing areas with lockers available for staff.

We saw dental equipment was in good condition and single use items were used, where appropriate. Most items were in sufficient numbers to enable effective decontamination between uses. However, a greater number of scaler handpieces were required to ensure these could be decontaminated between use with patients.

**The registered manager must ensure all reusable items are at sufficient numbers to enable decontamination between uses.**

Policies and procedures were in place to support the health, safety and wellbeing of patients and staff, with a suitable policy for business continuity also in place. Recent risk assessments for fire safety and health and safety had been conducted and we noted a comprehensive list of risks and their mitigations. However, the risk rating and scoring in the risk assessment documents for both fire safety and health and safety were all noted as '1', on a scale up to the potential score of '25'. The scoring of some activities did not match the guidance within the risk assessment

document which was in place to ensure the likelihood and severity of harm were correctly assessed. Therefore, we were not assured the practice was correctly assessing the risk to staff or patients.

**The registered manager must ensure risk assessments are completed in line with the guidance available to them.**

On review of the fire safety equipment and information, we found robust and comprehensive arrangements were in place in relation to physical fire safety. These included regular maintenance of fire safety equipment and clearly displayed fire safety and no smoking signs.

Suitable portable appliance testing certificates (PAT) were available for review and written confirmation of an electrical installation test inspection, due to take place the following week, was provided. The practice employer liability insurance certificate and Health and Safety Executive poster were also on display.

**Infection, prevention and control (IPC) and decontamination**

We found cleaning schedules were in place to promote regular and effective cleaning of the practice. However, we saw cleaning mops were being left to dry in the 'clean' area of the decontamination room, which was an area used for the packing of sterilised equipment. Due to the potential impact on patient safety, these concerns were resolved during the inspection. Further information on the actions taken by the service in respect of this matter are outlined in Appendix A.

Staff had sufficient access to Personal Protective Equipment (PPE) to support safe individual patient care. Appropriate hand hygiene arrangements and signage were in place at the practice.

We observed the environment was maintained to a satisfactory level which enabled effective cleaning and decontamination. The majority of equipment was also maintained to a good standard, however, we noted a tear in the material of a treatment chair in one of the surgeries. We were not assured that this chair could be cleaned effectively due to its condition.

**The registered manager must ensure equipment is maintained to enable safe cleaning and decontamination.**

We reviewed suitable records of daily autoclave machine cycle checks taking place for the two practice autoclave machines. However, we did not see evidence of foil testing taking place on the two ultrasonic baths. The Welsh Health Technical Memorandum (WHTM) 01-05 recommends a foil test of an ultrasonic device takes place quarterly.

**The registered manager must ensure all appropriate testing takes place on all cleaning and sterilisation equipment, when necessary.**

The practice decontamination room was directly connected to all three surgeries. Surgery one was on the 'clean' side of the room, while surgery two and three were both on the 'dirty' side of the room. This meant sterilised equipment would need to be transported back through the 'dirty' side of the decontamination room and could cause cross-contamination.

**The registered manager must ensure all sterilised equipment can be safely transported to surgeries.**

The training records we reviewed confirmed all staff had received appropriate training for IPC and the correct decontamination of equipment. The staff we spoke with were clear about their individual responsibilities in relation to infection control measures. The arrangements in place to prevent sharps injuries for staff were suitable but we did not see that staff had access to an occupational health provider.

**The registered manager must ensure that the staff members have access to an occupational health service, when it is required.**

We found the process for the Control of Substances Hazardous to Health (COSHH) was satisfactory, with the details collated in a comprehensive digital COSHH folder. We saw that all waste was stored and disposed of correctly through a suitable waste disposal contract.

**Medicines management**

We saw the arrangements in place for the management of medicines were appropriate. We noted a suitable policy for the safe handling, storage, use and disposal of medicines. The fridge designated for the storage of medicines was correctly managed, with temperature checks suitably logged.

Information at reception encouraged patients to speak to their clinicians about any changes in their medical history.

On inspection of the emergency equipment, we found all items were present, easily accessible and within their expiry dates. We noted routine checks took place on all emergency equipment. The staff records we reviewed evidenced suitable qualifications in cardiopulmonary resuscitation for all staff. Within the records, we noted five members of staff had attended a range of online first aid management

and medical emergencies in dentistry courses. However, no member of staff had attended a formal in-person first aid course.

Due to the potential impact on patient safety, this concern was brought to the attention of the practice manager on the day of inspection. Further information on the actions taken by the service in respect of this matter are outlined in Appendix A.

**Safeguarding of children and adults**
Suitable and up to date safeguarding procedures were in place to protect children and adults. The procedures included contact details for local support services, identified an appointed safeguarding lead and referenced the All-Wales Safeguarding Procedures. We saw any updates to procedures were communicated to the practice through Denplan. Changes were communicated to staff via an online compliance tool and in team meetings.

Within the records we reviewed, we saw staff were suitably trained in the safeguarding of children and adults. The staff we spoke with demonstrated an understanding of the safeguarding procedures and said they would know how to raise a concern and would feel supported to do so do.

**Management of medical devices and equipment**
We saw the clinical equipment was safe, in good condition and fit for purpose. Reusable dental equipment was used in manner which promoted safe and effective care. The staff we spoke with were confident in using the equipment and the training records we inspected confirmed they had received suitable training for their roles.

The radiographic equipment in the surgery had received their annual Electromechanical Test Examination in May 2023. However, it is recommended these tests occur annually.

**The registered manager must ensure all recommended radiographic equipment testing takes place routinely.**

We saw the practice radiation protection folder was up to date and comprehensive. On review of patient records, we found clinicians indicated patients were suitably informed of the risks and benefits of radiation. We noted the local rules were easily locatable in each surgery. The staff training records indicated all staff were trained to an appropriate level in radiography.

## Effective

**Effective care**
We found staff made a safe assessment and diagnosis of patients. The patient records we viewed evidenced that treatments were being provided according to clinical need and following professional, regulatory and statutory guidance.

The clinical staff we spoke with demonstrated clear understanding of their responsibilities while being aware of where to seek relevant professional advice, when needed.

We found suitable processes in place to record patient understanding and consent to surgical procedures. We saw appropriate use of clinical checklists to prevent wrong tooth site extractions.

**Patient records**
We reviewed a total of nine patient records during our inspection. The records were being held in in a secure digital system, in line with the General Data Protection Regulations. Overall, these records formed a contemporaneous and complete record of the care provided to patients. However, there were two patient notes which appeared void of any treatment information. When we spoke to staff regarding these notes it appears both patients received treatment, but the practitioner did not complete the notes as was required of them. We were assured the notes of these two patients were isolated incidents and were not a systematic issue. We noted the following areas which required improvement in the other seven records we reviewed:

- The justification for a radiograph, the clinical findings and the quality gradings were not recorded in two records
- Oral cancer screening was not recorded as taking place in any of the records we reviewed
- Electronic medical history submissions were not recorded as checked prior to treatment taking place in four records
- Evidence of written treatment planning was not noted in two patient records

**The registered manager must ensure complete patient records are kept at all times in line with GDC requirements and Faculty of General Dental Practice UK guidelines.**

# Quality of Management and Leadership

## Staff feedback

HIW issued a questionnaire to obtain staff views at the practice. In total, we received six responses from staff at this setting. One staff member said:

> *"The best place I have ever worked regarding patient care, policies, procedures and care of staff."*

## Leadership

**Governance and leadership**

We found a clear management structure in place to support the effective running of the practice. Staff meetings were held monthly and attended by all staff. On review of staff meeting minutes, we noted suitable discussions around health and safety as well as fire safety and policy reviews.

The staff we spoke to were engaging, knowledgeable and supportive of one another. Staff told us they had confidence in managers and would know who to speak to, if they needed help or support. The practice owner and practice administrator explained they had the correct support and training to undertake their leadership roles effectively.

The practice was an 'Excel' member of the Denplan group, as such they ran routine team development activities to drive improvements.

## Workforce

**Skilled and enabled workforce**

We observed good staff working relationships and noted a positive working environment at the practice. We also found an appropriate system in place to ensure a suitable number of qualified staff were working at any one time.

We found comprehensive and supportive arrangements in place to ensure all staff remained trained to an appropriate level for their roles. We reviewed a total of five out of ten staff records and found compliance with all mandatory training requirements, other than training in first aid mentioned elsewhere in this report. We also saw examples of good practice, with individual staff members completing relevant additional training above the mandatory expectations. A robust digital system was used to monitor compliance with staff training and maintain staff

records appropriately. From the records we reviewed and the staff we spoke with, we were assured staff were provided with time and support to complete training.

The staff we spoke with during the inspection explained they would know what to do and who to speak to in the event of a concern over service delivery, treatment or management. We saw the practice had a whistleblowing policy in place and staff were aware of the policy.

All of the staff records we reviewed had suitable indemnity insurance, GDC registrations and appraisals recorded. However, the process in place to ensure robust checks took place on the character and employment history of employees was not suitable. On review of the Disclosure and Barring Service (DBS) checks and references on file, we found:

- The principal dentist (and registered provider) had no reference checks recorded, nor evidence of an Enhanced DBS check recorded in staff files
- One of the two associate dentists had no evidence of any DBS check recorded
- One of the two associate dentists only had a Basic DBS check
- Two nurses only had Basic DBS checks
- No evidence was recorded in staff files of reference checks having taken place on the owner, employees or associate dentists.

Due to the potential impact on patient safety, we issued NJS Dental with a Non-Compliance Notice. Further information on the actions taken by the service in respect of this matter are outlined in Appendix B.

**The registered manager must review their employment procedures to ensure pre-employment checks routinely take place and that records are routinely reviewed to ensure compliance.**

## Culture

**People engagement, feedback and learning**

We saw a suitable system in place for the collection and review of patient feedback. We saw patient feedback forms available at reception and that patients were sent customer service reviews to complete online post-treatment. Feedback was routinely reviewed by managers and discussed in every team meeting to learn from findings and improve services for patients. However, we did not see any means to communicate any changes made as a result of feedback to patients.

**The registered manager should implement a means of communicating any changes made as a result of feedback to patients.**

The complaints procedure was available for patients to view at reception. There was a clearly defined timescale for an acknowledgement and a response to a complaint, along with how to raise a complaint. The details of HIW and the General Dental Council were included in the practice complaints leaflet for patients.

Complaints were overseen by the practice manager and collated using a suitable system. Verbal complaints were escalated to the practice manager and then recorded in the practice complaints log. There were no recent complaints for us to review during the inspection, but we were assured by the processes in place as outlined by staff.

## Learning, improvement and research

**Quality improvement activities**

We found the practice did have a quality improvement policy in place. We saw clinical audits for infection, prevention and control, along with radiographs and hand hygiene took place routinely. However, we did not see audits in place to continuously drive improvements on:

- Patient records
- Integrated smoking cessation
- Disability access.

We saw audit paperwork was available for an antibiotic prescribing audit which was noted as taking place in February 2023. However, this document contained no data and therefore we could not be assured this audit had taken place.

**The registered manager must review their quality improvement policy to include all mandatory audits and commence the required audits without delay.**

# 4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans 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 inspection.

As a result of the findings from this inspection 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.

# Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

| Immediate concerns Identified | Impact/potential impact on patient care and treatment | How HIW escalated the concern | How the concern was resolved |
|---|---|---|---|
| In the decontamination room we found the practice suction equipment was kept inside two cabinets. The two pieces of equipment produced noise which could be uncomfortable for staff working in this environment. | Any staff member who wished to use the room for an extended period could come in to contact with a higher amount of noise at work than could be considered safe. | This was escalated to the practice manager. | Practice management ordered ear protection for staff to use when in this room for an extended period of time. |
| We saw cleaning mops were being left to dry in the 'clean' area of the decontamination room, which was an area used for the packing of sterilised equipment. | Sterilised equipment could come in to contact with contaminated cleaning mops. | This was escalated to the practice manager. | All cleaning mops were moved immediately to a new storage area and amendments were made to the cleaning schedules to reflect these changes. |
| Within the records, we noted five members of staff had attended a range of online first aid management and medical | No staff member would be suitably qualified to respond to any person | This was escalated to the practice manager. | The practice manager booked two staff members on to an emergency first aid at work training course with a recognised provider on the date of inspection to be |

| | | | |
|---|---|---|---|
| emergencies in dentistry courses. However, no member of staff had attended a formal in-person first aid course. | experiencing a medical emergency. | | completed at the next possible available opportunity. |

# Appendix B - Immediate improvement plan

**Service:** NJS Dental

**Date of inspection:** 8 October 2024

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

| | Risk/finding/issue | Improvement needed | Standard / Regulation | Service action | Responsible officer | Timescale |
|---|---|---|---|---|---|---|
| 1. | The principal dentist (and registered provider) had no reference checks recorded, nor evidence of an Enhanced DBS check recorded in staff files<br><br>One of the two associate dentists had no evidence of any DBS check recorded | The registered manager must provide suitable evidence to HIW that Enhanced DBS checks are in place for all staff who may be in contact with vulnerable persons. | Section 18 (2) (e) of the Private Dentistry (Wales) Regulations 2017 | Registered with Mayflower going through the process for the enhanced DBS Checks | Pauline Jones | 2 months |

| | | | | | | |
|---|---|---|---|---|---|---|
| | One of the two associate dentists only had a Basic DBS check<br><br>Two nurses only had Basic DBS checks | | | | | |
| **2.** | No evidence was recorded in staff files of reference checks having taken place on the owner, employees or associate dentists. | The registered manager must provide suitable evidence to HIW that two reference checks are in place for all staff. | Section 18 (2) (e) | Provided Rebecca James' and uploaded & provided risk assessments for missing staff reference checks | Pauline Jones | 1-2 months |

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.

**Service representative:**

**Name (print):** **Pauline Jones**

**Job role:** **Practice Manager**

**Date:** **10/10/2024**

# Appendix C - Improvement plan

**Service:** NJS Dental

**Date of inspection:** 8 October 2024

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

| Risk/finding/issue | | Improvement needed | Standard / Regulation | Service action | Responsible officer | Timescale |
|---|---|---|---|---|---|---|
| 1. | A greater number of scaler handpieces were required to ensure these could be decontaminated between use with patients. | The registered manager must ensure all reusable items are at sufficient numbers to enable decontamination between uses. | Section 13 (3) (b) | Order more scaler handpieces | Practice Manager | 2 weeks |
| 2. | The risk rating and scoring in the risk assessment documents for both fire safety and health and safety were all noted as '1', on a scale up to the | The registered manager must ensure risk assessments are completed in line with the guidance available to them. | Section 16 (1) (b) | The risk assessments have been scored correctly as guided by the Inspector. | Practice Manager | 1 week |

| | | | | | | |
|---|---|---|---|---|---|---|
| | potential score of '25'. The scoring of some activities did not match the guidance within the risk assessment document which was in place to ensure the likelihood and severity of harm were correctly assessed. Therefore, we were not assured the practice was correctly assessing the risk to staff or patients. | | | | | |
| **3.** | The majority of equipment was also maintained to a good standard, however, we noted a tear in the material of a treatment chair in one of the surgeries. We were not assured that this chair could | The registered manager must ensure equipment is maintained to enable safe cleaning and decontamination. | Section 13 (2) (a) | Contacted a local Re upholsterer | Practice Manager | 1 month |

|  |  |  |  |  |  |  |
|---|---|---|---|---|---|---|
|  | be cleaned effectively due to its condition. |  |  |  |  |  |
| **5.** | We did not see evidence of foil testing taking place on the two ultrasonic baths. The Welsh Health Technical Memorandum (WHTM) 01-05 recommends a foil test of an ultrasonic device takes place quarterly. | The registered manager must ensure all appropriate testing takes place on all cleaning and sterilisation equipment, when necessary. | Section 13 (3) (b) | Foil tests to be done regularly and added to our routine list of checks. | Practice Manager | Ongoing |
| **6.** | The practice decontamination room was directly connected to all three surgeries. Surgery one was on the ‘clean’ side of the room, while surgery two and three were both on the ‘dirty’ side of the | The registered manager must ensure all sterilised equipment can be safely transported to surgeries. | Section 13 (3) (b) | Ordered 2 more transport boxes and updated our procedures. | Practice Manager | Ongoing |

| | | | | | | |
|---|---|---|---|---|---|---|
| | room. This meant sterilised equipment would need to be transported back through the ‘dirty’ side of the decontamination room and could cause cross-contamination. | | | | | |
| **7.** | We did not see that staff had access to an occupational health provider. | The registered manager must ensure that the staff members have access to an occupational health service, when it is required. | Section 18 (1) | Contacted a local firm Insightworkplacehealth.co.uk regarding private Occupational Health as & when required | Practice Manager | Ongoing |
| **8.** | The radiographic equipment in the surgery had received their annual Electromechanical Test Examination in May 2023. However, it is recommended these tests occur annually. | The registered manager must ensure all recommended radiographic equipment testing takes place routinely. | Section 13 (2) (a) | Contacted DD for annual tests | Practice Manager | 3 weeks |

| | | | | | | |
|---|---|---|---|---|---|---|
| **9.** | We noted the following areas which required improvement in the patient records we reviewed:<br><br>The justification for a radiograph, the clinical findings and the quality gradings were not recorded in two records<br><br>Oral cancer screening was not recorded as taking place in any of the records we reviewed<br><br>Electronic medical history submissions were not recorded as checked prior to treatment taking place in four records | The registered manager must ensure complete patient records are kept at all times in line with GDC requirements and Faculty of General Dental Practice UK guidelines. | Section 20 (1) | Dentists aware of this for the future. Meeting held to discuss these requirement and improvements will be made to patient records. | Practice Manager | Ongoing |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Evidence of written treatment planning was not noted in two patient records | | | | | |
| **10.** | We did not see any means to communicate any changes made as a result of feedback to patients. | The registered manager should implement a means of communicating any changes made as a result of feedback to patients. | Section 16 (2) | We have provided 'You Say, We Do' board in the reception | Practice Manager | On going |
| **11.** | We did not see audits in place to continuously drive improvements on:<br><br>Patient records<br><br>Integrated smoking cessation<br><br>Disability access.<br><br>We saw audit paperwork was available for an | The registered manager must review their quality improvement policy to include all mandatory audits and commence the required audits without delay. | Section 16 (1) (a) | Audits added to the IComply tasks | Practice Manager | On going |

| | | | | | |
|---|---|---|---|---|---|
| antibiotic prescribing audit which was noted as taking place in February 2023. However, this document contained no data and therefore we could not be assured this audit had taken place. | | | | | |

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.

**Service representative**

**Name (print):** **Pauline Jones**

**Job role:** **Practice Manager**

**Date:** **11/11/2024**