Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

General Dental Practice Inspection (Announced)

Abertawe Bro Morgannwg University Health Board, Dental Teaching Unit-Port Talbot Resource Centre

9 March 2016

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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

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1. Introduction

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

HIW's primary focus is on:

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

HIW completed an inspection at the Dental Teaching Unit, based within Port Talbot Resource Centre, Moor Road, Baglan, Port Talbot SA12 7BJ on 9 March 2016.

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

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

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

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

2. Context

The Dental Teaching Unit (DTU) was opened during 2010. It provides training to foundation dentists (dental graduates) in collaboration with the Wales Deanery (School of Postgraduate Medical and Dental Education).

The DTU is situated in a purpose built community resource facility close to Port Talbot town centre. General dental treatment is therefore provided to patients in the Port Talbot area of West Glamorgan. The DTU forms part of dental services provided within the area served by Abertawe Bro Morgannwg University Health Board (ABMUHB).

The staff team at the unit are employed by ABMUHB as the Unit is an integral part of services provided by this health board. The staff team includes a training programme director, two educational supervisors, and 10 foundation dentists at any one time, five of whom work at the DTU each week, on an alternate basis. The DTU team also includes a business manager, a team of six registered dental nurses, one support worker and two reception staff.

A range of NHS dental services are provided.

3. Summary

We observed that people visiting the DTU were treated with dignity and respect by the staff team. We also found that the team placed an emphasis on providing patients with individualised care in a timely manner.

We did however find that there was a need for some improvement to the content of the concerns (complaints) procedure in place. The health board was therefore advised to ensure that the procedure was produced in a format which was large enough for all patients to see clearly and displayed in a more prominent part of the waiting area.

Overall, we found that the DTU team provided patients with safe and effective dental care. Conversations with staff confirmed that they cleaned and sterilised used dental instruments carefully in a dedicated room which was visibly clean, tidy and well organised. We were also satisfied with the arrangements in place to ensure that X-ray equipment was used appropriately and safely.

The sample of patient's dental records we looked at provided evidence of individualised patient care although we did identify the need for some improvement to recording aspects of patients' consultations.

We further found that the health board needed to make improvements to the arrangements in place to demonstrate compliance with Health and Safety legislation.

The Dental Teaching Unit (DTU) was run by a training programme director on a day to day basis; supported by a business manager, two dental education supervisors and a wider team of friendly, professional and motivated staff. The service is however managed overall, by Abertawe Bro Morgannwg University Health Board. The DTU had a range of appropriate clinical procedures and quality assurance processes in place to ensure the safety of patients and staff.

Staff told us they enjoyed working at the DTU and were very well supported in their roles.

We did however identify the need for the health board to provide HIW with details of the action to be taken to ensure that formal arrangements are put in place as a means of peer support and review in respect of the training programme director and dental education supervisors. There was also a need to ensure that the training programme director and one of the dental education supervisors were provided with sufficient time and resource to help them maintain their own professional practice.

4. Findings

Quality of the Patient Experience

We observed that people visiting the Dental Teaching Unit (DTU) were treated with dignity and respect by the staff team. We also found that the team placed an emphasis on providing patients with individualised care in a timely manner.

We did however find that there was a need for some improvement to the content of the concerns (complaints) procedure in place. The health board was therefore advised to ensure that the procedure was produced in a format which was large enough for all patients to see clearly and displayed in a more prominent part of the waiting area.

Prior to the inspection, we asked staff working at the DTU to distribute HIW questionnaires to patients to obtain views on the dental services provided. Patient comments included:

> *'Really pleased with all the work I have had done. Dentist has been the best I've seen. Thank you'*
>
> *'Very polite, very gentle and informative'*
>
> *'I am more than happy with both the attitude and treatment of the dental practice. Keep up the good work'*
>
> *'The staff from the receptionist to the dentist have all been brilliant. I don't like coming to the dentist, but must say they put my worries to rest. Everyone is so helpful, professional and calming'*

Dignified care

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

We saw that the DTU reception was located a short distance away from the combined patient (dental and physiotherapy) waiting area; such seating being situated in an open communal space on the ground floor of the building

occupied by varying numbers of the public. This meant that staff were required to limit the use of patient's full details to minimise the possibility of people overhearing confidential conversations. We also saw that doors to dental surgeries remained closed at times when patients were receiving care.

One patient who completed a questionnaire indicated that they had overheard a senior member of staff offering information to another member of the team in an unhelpful manner on the day they visited the DTU. The person concerned did not however provide any additional comments as to whether they had reported this to the business manager at the time. This matter was brought to the attention of the dental team on the day of our inspection. The remaining fourteen patients, without exception, told us they felt they were always treated in a polite and welcoming way by all staff. The sample of patient records we saw also demonstrated that dentists had discussed individual patients' dental treatment with them.

The DTU (on behalf of Abertawe Bro Morgannwg Health Board (ABMU)) provided a range of NHS dental services and information about various dental costs, and eligibility for free NHS treatment, was clearly displayed in the waiting area for the benefit of patients.

We obtained a copy of the patient information leaflet and a supply of this was readily available for patients to take away with them. This meant that patients had access to key information about the practice that could be kept for future reference.

We found that the DTU website had not been updated since 2012. As a result the names/qualifications of the dentists were incorrect, as was the name of another member of the team. We therefore advised the staff team to contact the person responsible in the health board for making such amendments, in order that patients were provided with accurate service related information.

Timely care

We found that the DTU made efforts to ensure patients were seen in a timely manner. This was confirmed through comments received within completed HIW questionnaires which indicated that patients had never experienced any delays in being seen by the dentist on the day of their appointment. Staff also told us that they made sure they kept patients informed if their dentist was running late or unexpectedly absent; alternative arrangements then being offered.

An emergency contact telephone number for patients use was clearly displayed at the DTU reception. The number was also listed in the patient information leaflet. In addition, we were told that the DTU's answerphone message also informed patients of the correct number to call. This meant that patients could

access advice on how to obtain treatment when the service was closed. This was important, especially as the DTU is situated within a multi-occupied building and it is not possible to display emergency numbers on the front door due to existing safety measures.

Staying Healthy

We saw that a limited amount of health promotion material was available for patients to take away from the waiting area to help support them to take care of their own oral hygiene and health.

Written comments within completed HIW patient questionnaires also clearly indicated that patients felt they were given enough information about their care and treatment.

Individual Care

The DTU had arrangements in place to assist people with mobility difficulties to access the premises and receive care and treatment in a safe manner. For example, there were automatic doors at the entrance of the building from the designated parking area. We also found that all the dental surgeries were located on the ground floor.

We saw that there were disabled toilet facilities available to patients. However, the door leading to the toilet was notably heavy which meant that some patients may need assistance to gain access. We also highlighted the absence of signage within the building relating to the location of the DTU, but were informed that patients tended to ask for directions at the main reception desk at the entrance of the building.

Discussions with the business manager and senior dental nurse revealed that the DTU completed a patient survey on an annual basis. This was as a means of obtaining people's views on services provided and to identify any areas for improvement. We were provided with a copy of the survey analysis completed during August 2015 and saw that the service had received numerous positive comments and responses from patients.

We found that the DTU had a written health board procedure for dealing with concerns (complaints) about NHS dental treatment. We were also provided with information about the nature of the complaints which had been brought to the attention of the service in the past three years. Complaints had been very

few, and each of them had been acknowledged and resolved within timescales prescribed by the NHS '*Putting Things Right*'[1] arrangements.

Eight patients who returned HIW questionnaires stated they did not know how to make a complaint about dental services they receive, if needed. In addition, the complaint procedure did not contain contact details for the local community health council in accordance with patients' rights to seek their support/advocacy with any concerns they may have. We further noted that the procedure did not contain contact details associated with the health board. We saw the complaint procedure was displayed high up on the wall and was produced in small print which meant that some people with visual difficulties may not be able to read it.

Improvement needed

The health board is required to provide HIW with details of the action taken to ensure that patients are provided with a prominent display of accurate NHS complaints information consistent with 'Putting Things Right' arrangements.

[1] In April 2011 the Welsh Government introduced new arrangements for the management of concerns within the NHS: *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.

Delivery of Safe and Effective Care

Overall, we found that the Dental Teaching Unit (DTU) provided patients with safe and effective dental care. Conversations with staff confirmed that they cleaned and sterilised used dental instruments carefully in a dedicated room which was visibly clean, tidy and well organised. We were also satisfied with the arrangements in place to ensure that X-ray equipment was used appropriately and safely.

The sample of patient's dental records we looked at provided evidence of individualised patient care although we did identify the need for some improvement to recording aspects of patients' consultations.

We further found that the health board needed to make improvements to the arrangements in place to demonstrate compliance with Health and Safety legislation.

Safe Care

We saw that the DTU had completed a health and safety risk assessment of the premises in recent years. No remedial action was required. We were also informed that the building manager (employed by the health board to oversee health and safety in the multi-occupied building) had a prominent role for ensuring compliance with health and safety legislation. This meant that efforts had been made to ensure the safety of patients and staff. A tour of the premises also revealed that all areas of the building occupied by staff and patients were very well maintained.

We found that the DTU team had put together a file which held information/data sheets about all possible use of substances which fall into the category of the Control of Substances Hazardous to health (CoSHH). However, there was no risk assessment to guide staff about what products were being currently used and what action needed to be taken in the event of direct contact.

Improvement needed

The health board is advised of the need to provide HIW with the action taken to ensure that staff have access to a current risk assessment regarding all CoSHH substances in use. This is in accordance with Health and Safety Regulations.

We held discussions with the dental team with regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations which came into force on 11 May 2013. The above regulations supplemented the existing health and safety

legislation that already required employers across all sectors to take effective action to control the risk from sharps injuries.

Whilst we were told that the team had undertaken a risk assessment to determine whether they had effective arrangements in place for the safe use and disposal (including 'safer sharps' where reasonably practicable), it was not possible to be assured that the service was compliant with the 2013 legislation.

Improvement needed

The health board is required to provide HIW with full details of the action taken/to be taken to demonstrate compliance with the Health and Safety (Sharp instruments in Healthcare) Regulations.

There was a waste collection and disposal contract in place and we were satisfied with those arrangements. Clinical waste awaiting collection was stored in a bin to the rear of the premises. Whilst this was within a locked storage area, we did see that the bin was not locked. This meant that there was the potential for members of the public to come into contact with hazardous waste during service opening hours. We brought this matter to the attention of the team so that the building manager could be informed, as a number of services operating from the premises used the same facility for storing waste.

Observations regarding the DTU environment highlighted that the health board needed to amend its fire evacuation instructions to alert members of the public and staff to the correct assembly point. We also saw that the required workplace Health and Safety poster was not the current version that should be displayed for staff information purposes.

Improvement needed

The health board is required to describe the action taken to ensure that its written fire evacuation procedure is correct. The health board is also required to inform HIW as to the action taken to display an up to date version of the required workplace Health and Safety poster.

We were able to confirm that portable (electrical) appliances testing (PAT) had been completed by the building manager in the past twelve months.

There was a dedicated decontamination room at the DTU where instruments were cleaned and sterilised following use. The room was clean, tidy and designed so that the flow of instruments, (from dirty to clean) followed best

practice guidelines as set out within the Welsh Health Technical Memorandum (WHTM) 01-05[2](Revision 1)

Conversations with dental nursing staff demonstrated that there were well understood processes in place in place for the purpose of completing required equipment checks in the decontamination room at the start and end of each day. This was supported by records which confirmed that daily, weekly and monthly equipment checks had been conducted. We were also provided with a comprehensive and satisfactory description of the established procedures in place for the cleaning and sterilisation of instruments.

We found that dental instruments were appropriately packaged following sterilisation. We also saw that instrument packaging was stamped with the date that the instruments had been sterilised and a 'use by' expiry date prior to storage, to guide staff as to when they should be used for the protection of patients.

We were provided with a copy of a WHTM 01-05 infection control audit which had been commenced during February 2016 and was therefore on-going. A previously completed audit (2014) had enabled the dental team to self assess their practice against the guidance and to develop an improvement plan, as part of the continuous improvement process required.

The DTU had procedures in place to deal with a range of patient emergencies. Staff had access to resuscitation equipment and emergency drugs in the event of a patient emergency (collapse) at the practice. These were stored securely. However, we found the following:

- There was an emergency equipment/drug checklist in place. However this was completely separate from the weekly form that staff signed to confirm that everything was in date and ready for use. This meant that there was room for error within the checking process
- Staff were aware of where the emergency drugs were stored (and reference to this was made in the induction pack to assist new staff). However, the majority of the drugs were incorrectly stored in the practice fridge. In addition, two other emergency drugs were being stored elsewhere; one being kept outside of the department in

[2]The Welsh Health Technical Memorandum (WHTM 01-05) (Revision 1) document provides professionals with guidance on decontamination in primary care practices and community dental practices.

another part of the building. Given the need to ensure that emergency drugs are accessed in a very prompt manner in the event of an emergency (patient collapse), this issue must be addressed

- Flow charts relating to the use of emergency drugs were present alongside the drugs. However they were contained in open folders which meant that they could potentially become separated

Improvement needed

The health board is required to inform HIW of the action taken to ensure that there are robust arrangements in place to assist staff to respond to patient emergency situations that may arise.

We saw certificates that indicated staff had received recent training on how to deal with medical emergencies and how to perform cardiopulmonary resuscitation (CPR).

We were able to confirm that the DTU had a member of staff working each day who was trained in the use of first aid.

We found that the DTU had an adult and child safeguarding policy in place. We also saw that staff had easy access to contact numbers for local safeguarding teams. There were also training records available confirming that the dental team had undertaken child and adult safeguarding training.

Further examination of staff records showed that they had received regular training on a number of relevant and required topics. This meant that there was an emphasis on ensuring that they were competent in providing safe care to patients.

There was a wide range of appropriate, current corporate and locally developed health board policies and procedures in place for staff to follow during the course of their work. Conversations with staff revealed that they knew how to access that information as and when needed.

We saw a variety of equipment maintenance certificates during our inspection. We were therefore, able to confirm that suitable arrangements were in place to ensure that all equipment was inspected according to regulatory requirements. This meant that patients could be treated safely.

We found that appropriate arrangements were in place for the safe use of radiographic (X-ray) equipment. This included relevant staff training and equipment maintenance and testing. We also saw that X-ray audits had been conducted to help ensure the quality of the images taken and the reasons why they had been performed.

We were provided with a copy of a document which we were told had been sent to the Health and Safety Executive (HSE) during 2010 (when the service opened) to inform the HSE that the service had X-ray equipment on the premises-as required. However, the document did not indicate who it was sent to. Neither was the service able to provide us with evidence of a response from the HSE in the form of a letter, or email. We therefore spoke with the nominated Radiation Protection Adviser and requested that this matter be pursued.

Effective Care

The DTU used an electronic patient records system. Overall, we saw that the content of 12 patient records was detailed and demonstrated care had been planned and delivered in a manner to ensure their safety. However, we found that the consistency of recording aspects of patient consultations could be improved as follows:

- Social history (including smoking and alcohol consumption) was not always recorded. This is important information as such lifestyle choices are known to adversely affect the health of a patient's mouth and teeth
- Basic Periodontal Examination (BPE),(a type of examination of areas/tissues in the mouth to identify gum disease) was not always recorded
- The recording of updated medical histories was inconsistent, (which would provide evidence that the dentist had checked a patient's medical conditions prior to treatment)
- Two patient records failed to provide evidence that the DTU was adhering to visit recall guidelines

Improvement needed

The health board is advised of the need to describe how it will ensure that all patients' records contain complete and information in accordance with professional standards and guidance.

We were provided with health board information which indicated that the DTU team were 'high referrers' to services available that encouraged and supported patients to stop smoking.

The DTU team regularly and continually audited relevant aspects of practice and service delivery. Audit topics were identified using a range of tools such as Maturity Matrix Dentistry[3]. The audit tools used at the DTU were sourced from Welsh Government, Welsh Deanery and Dental Protection and were also based on guidelines produced by the Faculty of General Dental Practitioners (FGDP)[4]. We were also informed that the outcomes of all audit activity were discussed in team meetings; learning implemented and re-audits performed.

We were made aware of a variety of individual and team audit activity that had been completed in the past two years (associated with decontamination, patient appointment recall arrangements, patients' medical histories and service access by emergency patients) as a means of identifying, and making, improvements to the services provided to patients. The service completed a further audit in relation to the content of patients' record cards following our inspection.

[3] Maturity matrix dentistry is a practice development tool which helps dental teams deliver high quality care for patients.

[4] The FGDP (UK) exists to improve standards of patient care. This organisation provides dental professional with quarterly information about the latest research and articles on dentistry. http://www.fgdp.org.uk/members/membersonlineresources/members-logo/what-is-an-fgdpuk-member.ashx

Quality of Management and Leadership

The Dental Teaching Unit (DTU) was run by a training programme director on a day to day basis; supported by a business manager, two dental education supervisors and a wider team of friendly, professional and motivated staff. The service is however managed overall, by Abertawe Bro Morgannwg University Health Board. The DTU had a range of appropriate clinical procedures and quality assurance processes in place to ensure the safety of patients and staff.

Staff told us they enjoyed working at the service and were very well supported in their roles.

We did however identify the need for the health board to provide HIW with details of the action to be taken to ensure that formal arrangements are put in place as a means of peer support and review in respect of the training programme director and education supervisors. There was also a need to ensure that the training programme director and one of the dental education supervisors were provided with sufficient time and resource to help them maintain their own professional practice.

The Dental Teaching Unit-Port Talbot is part of NHS dental services provided and managed by Abertawe Bro Morgannwg University Health Board. All staff are employed directly by the health board. The training programme director was actively involved in the day-to-day running and management of the DTU; working closely with a friendly, professional, motivated staff team. Discussions held with a number of the dental team clearly demonstrated that a positive working culture was encouraged by senior staff and individuals supported one another well during their working day.

We found that clinical staff were registered with the General Dental Council (GDC) and had indemnity insurance cover in place.

We saw that records were available that demonstrated staff had received immunisation against Hepatitis B. This was as a means of protecting patients and themselves from infection.

The nursing and administrative element of the staff team was well organised and we were told that the DTU never used agency dental nurses. This meant that patients were treated by a core group of staff who understood what was expected of them and a team that were familiar to them.

The dental team had the skills, confidence and competence required to meet the care and treatment needs of patients. For example, we found that the DTU

had developed an induction programme to ensure that any new members of the dental team were provided with a means of becoming familiar with established processes and procedures in relation to patient services. Discussions with the training programme director revealed the efforts made to provide 1:1 formal and informal group supervision for the foundation dentists. This included opportunities for learning through the observation of dental procedures and subsequent discussions with a senior member of the team.

We also discussed the support arrangements in place for the training programme director and dental education supervisors, as we recognised the challenges they faced in managing the busy unit and supporting the foundation dentists. Whilst each of the individuals provided some informal support for one another, no formal arrangements were in place for their supervision and support. In addition, we found that two of the three professionals concerned were not able to undertake dental practice sessions in their own right due to a stated insufficient number of dental nurses employed at the service.

Improvement needed

The health board is advised of the need to provide HIW with details of the action to be taken to ensure that formal arrangements are put in place as a means of peer support and review with regard to the training programme director and dental education supervisors. There is also a need to ensure that the training programme director and one of the education supervisors are provided with sufficient time and resource to help them maintain their own professional practice.

Staff we spoke to told us they felt very well supported in their work. They also told us that they, along with the dentists, attended monthly staff meetings where they took opportunities to raise any issues of concern about services being provided to patients. Such meetings were also used to convey new/relevant information to the dental team. We saw a sample of minutes taken at the most recent meeting which showed that discussions had taken place around a variety of relevant operational issues which included patient access/numbers and audits that were taking place (in relation to patient recall, sterilisation, and smoking).

We found that the business manager was in the process of developing a system for conducting annual staff appraisals. Such a system will, in the future, enable one to one discussions to take place with staff to determine whether training provided has been effective, as well as planning training for the future.

Discussions with staff demonstrated that they felt confident to raise any concerns they may have about services provided at the DTU. A whistleblowing

policy was also found to be in place in the event that staff may feel the need to raise any issues of concern about service delivery ‘outside’ of the dental team.

5. Next Steps

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

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

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

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

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

6. Methodology

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

Figure 1: Health and Care Standards

Any dentist working at the practice who is registered with HIW to provide private dentistry will also be subject to the provisions of the Private Dentistry (Wales) Regulations 2008[5] and the Private Dentistry (Wales) (Amendment) Regulations 2011[6]. Where appropriate we consider how the practice meets these regulations, as well as the Ionising Radiation Regulations 1999, the Ionising Radiation (Medical Exposure) Regulations 2000 and any other relevant

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

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

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

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

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

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

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

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

Appendix A

Dental Service: Improvement Plan

Practice: The Dental Teaching Unit-Port Talbot Resource Centre

Date of Inspection: 9 March 2016

Page Number	Improvement Needed	Regulation / Standard	Practice Action	Responsible Officer	Timescale
Quality of the Patient Experience					
Page 8	The health board is required to provide HIW with details of the action taken to ensure that patients are provided with a prominent display of accurate NHS complaints information consistent with 'Putting Things Right' arrangements. (GDC guidance 5.1)	Standard 6.3	Amended policy now includes relevant information: CHC contact details, LHB contact details. Poster in waiting area: font enlarged and repositioned to a more prominent position	Debbie Lamin Business Manager	March 2016

Page Number	Improvement Needed	Regulation / Standard	Practice Action	Responsible Officer	Timescale
Delivery of Safe and Effective Care					
Page 9	The health board is advised of the need to provide HIW with the action taken to ensure that staff have access to a current risk assessment regarding all CoSHH substances in use. This is in accordance with Health and Safety Regulations.	Standard 2.1	All risk assessments are now up to date in line with Health and Safety regulations. Compliance with CoSHH regulations has been achieved and advice/reassurance sought from ABMU Lead in Health and Safety for the future.	Joanna Cloke Senior Dental Nurse	April 2016 and ongoing
Page 10	The health board is required to provide HIW with full details of the action taken/to be taken to demonstrate compliance with the Health and Safety (Sharp instruments in Healthcare) Regulations.	Standard 2.1	The Health Board has investigated the In-Safe sharps system as per recommendations from HIW which will be implemented in September 2016 with the new intake of Foundation Dentists	Elisabeth Samway Educational Supervisor	September 2016
Page 11	The health board is required to describe the action taken to ensure that its written fire evacuation procedure is correct. The health board is also required to inform HIW as to the action taken to display an up to date version of the required workplace Health and Safety poster.	Standard 2.1	An up to date Health and Safety poster is now on display. As per ABMU regulations, all staff have had updated fire safety training annually by ABMU's Fire Safety Advisor/Officer and can access on line training.	Debbie Lamin Business Manager	April 2016

Page Number	Improvement Needed	Regulation / Standard	Practice Action	Responsible Officer	Timescale
Page 13	The health board is required to inform HIW of the action taken to ensure that there are robust arrangements in place to assist staff to respond to patient emergency situations that may arise.	Standard 2.9	As per HIW recommendations all emergency drugs are held in a central location in fastened pouches. All staff undertake annual medical emergency training within the unit.	Joanna Cloke Senior Dentist Nurse	April 2016
Page 14	The health board is advised of the need to describe how it will ensure that all patients' records contain complete and information in accordance with professional standards and guidance. (GDC guidance 4.1)	Standard 3.5	The Health Board will ensure the dental unit carries out regular audits of the patient's records, and continue to do so to improve all aspects of information gathered.	Lesley Taylor Training Director	Immediately and ongoing
Quality of Management and Leadership					
Page 17	The health board is advised of the need to provide HIW with details of the action to be taken to ensure that there are formal arrangements put in place as a means of peer support and review for the training programme director and dental education supervisors. There is also a need to ensure that the training programme	Standard 7.1	The Health Board will ensure that the Senior Dentists have annual appraisals and peer reviews. We will promote open dialogue between senior management and the educational supervisors. The educational supervisors will hold their own clinics when the foundation dentists are on their	Lindsay Davies Head of Primary Care and Planning	Current and ongoing

Page Number	Improvement Needed	Regulation / Standard	Practice Action	Responsible Officer	Timescale
	director and one of the dental education supervisors are provided with sufficient time and resource to help them maintain their own professional practice.		training days to maintain their own professional practice.		

Health Board Representative:

Name (print): **Lindsay Davies.....**

Title: **Head of Primary Care and Planning.....**

Date: **24/08/2016.....**