Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Dental Follow-up Inspection (announced)

Elegant Dental Care

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

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced follow-up inspection of Elegant Dental Care (formally known as Bush Street Dental) on the 13 March 2018.

Our team, for the inspection comprised of one HIW Inspector and one clinical peer reviewer. The inspection was led by a HIW inspection manager.

Further details about how we conduct follow-up inspections can be found in Section 5.

2. Summary of our inspection

We found the majority of recommendations made in 2016 had been addressed.

Complaints information contained HIW's details in line with regulatory requirements. We saw that formalised, documented meetings were taking place on a biannual basis and staff had a programme of training in place. Immunisation records were evident in staff files demonstrating staff had the necessary vaccinations.

We found that previous recommendations relating to radiographic equipment and documentation had been met. The radiation protection file had been updated accordingly and x-rays were being justified in patient notes, including the recording of any x-ray findings.

We identified that some recommendations made in 2016 had not been fully met and further improvement was required. Specifically to ensure medical histories are being countersigned and updated in patient notes at each course of treatment and verbally at each appointment. We found that dental materials were being checked to ensure they were in date but this was not being recorded.

We saw that improvements had been made to the decontamination environment and processes. However, we identified some bagged sterile instruments that were without dates and some with wrong dates.

This is what we found the service did well:

- There was evidence to demonstrate that all staff had completed training in essential areas, including safeguarding and medical emergencies

- Staff had developed a programme of formalised, biannual team meetings which were documented
- Complaints information contained details for HIW in line with regulatory requirements

This is what we recommend the service could improve:

- Medical histories need to be fully recorded in patient notes
- Portable appliance testing (PAT) needs to be undertaken to ensure appliances are safe for use
- Ensure the bagged sterile instruments are dated appropriately and consistently, to include the date of sterilisation and use by date

There were no areas of non compliance identified at this inspection.

3. What we found

Background of the service

HIW last inspected Elegant Dental Care (formally known as Bush Street Dental) on 3 August 2018.

The key areas for improvement we previously identified included the following:

Immediate assurance issues identified:

- The practice must ensure all dental materials were within the suggested expiry dates. Specifically, we found materials in the surgery, which are used for treatment, were well beyond their expiry dates
- All staff must be able to demonstrate that they have received the necessary Hepatitis B vaccinations
- The practice was required to have a current, written scheme and a legionella risk assessment undertaken by a competent person; generally members of the Legionella Control Association

Other Improvements needed:

- The practices' concerns information should have included the HIW address as required by regulation
- The practice needed to ensure that there are waste disposal facilities available for female sanitary waste
- The practice needed to ensure that current, valid maintenance certificates were available to evidence that equipment was maintained and safe for use
- The dentist needed to ensure that clinical areas were fit for purpose, clean and hygienic.
- The practice needed to set a short timescale for the development of the decontamination room
- The practice needed to improve the decontamination process and environment whilst waiting for the development of the decontamination room

- The practice was required to consider the use of the audit tool for infection control as suggested by WHTM 01-05 (Revision 1).[1]
- The practice needed to develop a resuscitation policy which is in line with Resuscitation UK guidelines
- The practice needed to ensure all emergency equipment is checked regularly to ensure recommended dates have not elapsed
- The practice needed to ensure that the identified First Aider has received appropriate recognised training
- The dentist needed to ensure that radiograph practice is in line with current legislation and guidance
- The dentist needs to ensure that patient records contain the required information, including countersigned medical histories
- The practice needs to develop formalised staff meetings with recorded minutes
- The practice needs to ensure that staff receive appropriate training on a regular basis in line with current legislation and guidance.

For the full report and improvement plan from 2016, click here: http://hiw.org.uk/find-service/service-index/bushstreetdental?lang=en

The purpose of this inspection was to follow-up on the above improvements identified at the last inspection.

[1] 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.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

The recommendation identified in 2016 regarding concerns information had been addressed. We saw that HIW contact details were included in the complaints procedure, which is required by regulation.

We asked the practice to consider introducing a formal system to capture verbal/informal communications which would ensure that any themes emerging can be identified.

To support the complaints process, we recommended a complaint log is put in place. This will enable staff to monitor the stages of the process and ensure complaints are dealt with timely as well as providing themes/trends for the service to consider.

What improvements we identified

Areas for improvement identified at last inspection included the following:

Patient Experience/Concerns Information

- The practice's concerns information should include the HIW address as required by the regulations.

What actions the service said they would take

The service committed to take the following actions in their improvement plan dated September 2016:

Patient Experience/Concerns Information

- HIW contact information added to all necessary documentation

What we found on follow-up

The practice's procedure for dealing with concerns (complaints) about private dental treatment had been updated and included HIW's address, in accordance with the regulations.

Additional findings

Prior to the inspection, we invited the service to distribute HIW questionnaires to patients to obtain views on the services provided. A total of 18 were completed. Patient comments included the following:

> *"Keep doing what they are doing, they are brilliant"*
>
> *"All the staff are friendly and reassuring. I am given good advice and options to consider before starting treatments. I find the text reminders about appointments helpful"*
>
> *"The staff are very friendly and make me feel at ease when I come in for my appointments"*

The majority of those patients who completed a HIW questionnaire stated that they knew how to raise a concern or complaint about the dental services they received at the practice.

The process for how verbal/informal feedback from patients is dealt with was discussed and whilst these are usually passed to the dentist to deal with at the time, we recommended that a system is put in place so they can be captured formally. The practice will then be able to analyse all entries, and where applicable, recognise areas of good practice as well as areas where improvements may be required.

We saw that all complaints were stored in a file, but recommended a complaint log be put in place. This will provide a place to record complaint information; ensure that complaints are handled in a timely manner, as well as providing a tool for identifying trends.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Following recommendations made in 2016 we found that the practice had made progress to address the areas identified.

Evidence was available to confirm staff had received necessary vaccinations. Certificates and assessments were seen which confirmed that legionella[2] testing and the maintenance of the compressor[3] had taken place. However portable appliance testing (PAT) had not been undertaken to ensure the equipment is being maintained appropriately and is safe to use.

We saw that improvements had been made to improve the decontamination processes and the environment. We identified some bagged sterile instruments that were without dates and some with wrong dates and recommended that these are checked inline with WHTM 01-05 guidelines.

Recommendations made in 2016 about the radiographic equipment and documentation had been completed.

Our review of patients notes found they were more detailed but medical histories still needed to be captured and recorded.

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[2] Legionella is the bacterium which causes legionnaires' disease, flourishing in air conditioning and central heating systems.

[3] A dental air compressor pressurizes atmospheric air for use in dental procedures. After capturing and compressing oxygen, it cleans and dries the gas and stores it away to be used for handsets, drills, and other types of units that need out ultra-clean compressed air to function.

What improvements we identified

Areas for improvement identified at last inspection included the following:

Safe & Effective Care/immediate assurance

- The practice must ensure all dental materials are within the suggested expiry dates. Specifically, we found materials in the surgery, which are used for treatment, were well beyond the expiry dates
- All staff must be able to demonstrate that they have received the necessary Hepatitis B vaccinations
- The practice is required to have a current, written scheme and a legionella risk assessment undertaken by a competent person; generally members of the Legionella Control Association.

Safe & Effective Care

- The practice needs to ensure that there are waste disposal facilities available for female sanitary waste.
- The practice needs to ensure that current, valid maintenance certificates are available which evidence that equipment is being maintained and is safe for use
    - The Legionella testing was out of date and the recommendations made in the last report (2014) had not been carried out
    - Portable appliance testing (PAT) had not been carried out
    - The certificate of maintenance for the compressor was out of date (21/7/15). We were told the maintenance check was due the day following our inspection. We requested a copy of the certificate. HIW had not received this on the 16/8/16.

- The dentist needs to ensure that clinical areas are fit for purpose, clean and hygienic. For example;
    - Doors to cupboards did not close securely
    - Drawers containing dental material and equipment were unclean and disorganised
    - Generally the practice was untidy, especially the second clinical room (which was being used for storage of boxes, broken equipment and paper quality testing strips) Rolls of paper records had been thrown on the worktop (for the past three years) making it very difficult to audit or find a particular testing result. The room was disorganised, messy and cluttered
    - We also saw an old Velopex (x- ray developing machine) which did not work but was stored in the clinical area. This machine needs to be decommissioned.
- The practice needs to set a short timescale for the development of the decontamination room.
- The practice needs to improve the decontamination process and environment whilst waiting for the development of the decontamination room including;
    - The flooring was not appropriate with some areas showing bare concrete. The floor was dirty and the covering was difficult to clean
    - The practice did not follow the correct passage of dirty in, clean out practice. This meant that dirty equipment was taken past clean equipment when entering the room
    - There was lack of appropriate work area to ensure equipment was thoroughly cleaned
    - There was only one sink rather than two and not sufficient room to use a bowl as well as the sink. There was no separate hand washing sink.
    - There was lack of storage for equipment which is used to undertake and maintain records of satisfactory decontamination processes

- We did not see a well established and thorough approach to this aspect of the service. The verbal description of the decontamination process currently in place did not assure us that decontamination of equipment was robust

- Although checks were being undertaken we were not assured that the decontamination process was robustly supported by detailed records of daily and other regular safety checks regarding the effective operation of the equipment.

- There was a second autoclave (sterilising machine) in the hygienist's room. It was unclear whether this was in use or not. It was unclean and not plugged in. We were told that it was kept as a backup. This needs to be maintained appropriately if it remains in use, or removed from the premises if it is no longer in use

- Bagged sterile instruments only had a month written on it. This does not ensure that instruments use by dates are clearly visible. Best practice is to have sterilised date and use by date.

- We did not see evidence of the recent completion of thorough infection prevention and control audit as suggested by the Welsh Health Technical Memorandum WHTM 01-05 (Revision 1).

- The practice should consider the use of the audit tool for infection control as suggested by WHTM 01-05 (Revision 1).

- The practice needs to develop a resuscitation policy which is in line with Resuscitation UK guidelines.

- The practice needs to ensure all emergency equipment is checked regularly to ensure recommended dates have not elapsed

- The practice needs to ensure that the identified First Aider has received appropriate recognised training.

- The dentist needs to ensure that radiograph practice is in line with current legislation and guidance. Specifically;

    - The radiation protection file was not completed as required

    - There were very few x-rays being taken. Of the five patient records looked at three had no x-rays, one had an x-ray in

2013 and one had very limited x-rays taken. This is not in line with current guidelines

- Patient's records did not include records to justify why certain dental x-ray views had been taken or not
- There was no recording of the findings from the x-rays
- The nurse quality assured the image quality of x-rays but the gradings were not audited
- Identification of controlled areas were only in the radiation file and not near the equipment.

- The dentist needs to ensure that patient records contain the required information, specifically;
  - Notes had limited information with very little detail regarding; why the patient had attended, what was examined, the findings and discussion regarding the treatment plan
  - The medical history was reported but the information given by the patient was not countersigned by the dentist to evidence that there had been discussion regarding any changes.

What actions the service said they would take

The service committed to take the following actions in their improvement plan:

Safe & Effective Care/immediate assurance

- Out of date materials were not being used. All expiry dates checked and expired disposed of.
- Hepatitis B seroconversion tests carried out on all staff. Necessary action taken
- Legionella Risk Assessment carried out 6/9/16 by Bison Assist

Safe & Effective Care

- Feminine Hygiene bin to be placed in ladies toilet
- Legionella and pseudomonas testing carried out

- portable appliance testing to be arranged
- Compressor Maintenance carried out (appointment cancelled for 4/8/16 by) Certificate received by post 6/9/16 forwarded to HIW by email immediately
- Cupboard doors to be inspected and repairs carried out (door in surgery 2 fell broke on inspection day and was repaired immediately but was secured shut to allow glue to dry) Surgery 3 has a broken cupboard door but is currently not used as a clinical area; it is used as an office space and storage. The inspectors were informed of this on inspection day and attention drawn to the Out Of Order sign on the door. The inspectors requested a room to use during the inspection with access to a computer terminal, as both surgeries were in use and reception was too public, there was no other option.
- The Velopex machine was only decommissioned in July. The unit will be removed when a plumber is available to cap off water supply. The area the machine is situated is no longer a clinical area, but a staff changing and stock room.
- Consultation on logistics of moving decontamination room already undertaken. Original planned location unsuitable, major works required to utilise partially built rear extension as new location.
- New flooring to be laid
- Only one staff member carries out decontamination at any time. Clean instruments are boxed and removed before dirty instruments are collected
- Non essential equipment and clutter removed to provide more workspace and room for bowl and sink to be used
- Cupboards in decontamination room emptied and cleaned to be used for storage of equipment used to undertake and maintain records of satisfactory decontamination processes
- Decontamination training booked. Isopharm decontamination record books to be purchased and used to ensure correct testing carried out at correct intervals and to facilitate storage of results of testing
- Second autoclave had only been recommissioned by the engineer on 2/8/16 .The autoclave is a backup autoclave in case of main autoclave failure. It is only used if the main autoclave fails, it would be swopped with the main autoclave in the decontamination room. It is now possible to properly maintain it again.

- Bagged sterile instruments now have a 'sterilised on' date and use by date on the bags
- Infection control audit to be carried out
- Audit to be carried out
- Resuscitation policy to be reviewed and updated
- All emergency equipment checked monthly and expiry dates recorded
- First aid training to be undertaken
- Radiation Protection file to be reviewed and updated
- Radiographic use increased according to current guidelines. Current guidelines reviewed and familiarised.
- Justification for taking radiographs included in patient notes following Dental Protection Record Keeping course in May 2015. Justification for not taking radiographs now recorded. Recording of findings of radiographs have been included in records since Dental Protection Record Keeping course in May 2015.
- Radiograph Audit to be carried out and reviewed after 6 months
- Controlled Areas to be clearly identified with adequate signage
- Record Keeping to be improved, to be set out in a more comprehensive way to make it easier to read and more detail included
- Medical Histories now countersigned

What we found on follow-up

Managing risk and health and safety

We observed that a feminine hygiene bin had been placed in the toilet following the visit in 2016. However, discussions confirmed that there was no contract in place for the bin to be emptied, with staff responsible for the removal of waste. Under the Duty of Care Act, there is a legal requirement for a business to manage sanitary waste to the point of disposal. This means employees cannot be made responsible for disposing of the waste themselves. This issue needs to be resolved and appropriate measures put in place for the collection of this waste.

We identified that certificates were in place for legionella testing, dated September 2016. The certificate of maintenance for the compressor was sent to HIW in 2016 and we saw the original certificate at the time of our follow up visit. Due to unforeseen circumstances, the portable appliance testing (PAT) certificate was not available. The PAT was going to be re-arranged and we have requested that a copy of the certificate is provided to HIW once completed.

Improvement needed

The practice must review the current arrangements of staff disposing of feminine hygiene waste and arrange for appropriate waste collection.

Portable appliance testing (PAT) to be carried out as soon as possible and a copy of the certificate to be sent to HIW

Infection prevention and control (IPC) and decontamination

We observed that the decontamination room in 2016 was not meeting best practice as defined by WHTM 01-05. It was recommended that the decontamination process and environment needed to be improved. This is what we found in 2018:

- We observed that new flooring had been laid which ensured that the bare concrete was covered. This enabled the floor to be cleaned more appropriately
- The process staff used in 2016, whereby dirty equipment was taken past clean equipment when entering the room was observed to have changed and was inline with the process described in the improvement plan. We saw that staff boxed clean instruments and removed these from the decontamination room before dirty instruments were collected
- Despite the decontamination room being in the same location, there had been changes made to the room that enabled a better flow to the decontamination process. We saw that a washing up bowl was used for cleaning dirty instruments and the sink used for rinsing. There were separate hand washing facilities available which the room did not have in 2016
- The practice told us in their improvement plan that the cupboard in the decontamination room had been emptied and cleaned in order to

provide storage of equipment. However, on our follow up visit we saw that the cupboard had been removed. As a result we found the space to be cluttered. We asked staff to address this issue at the time of our visit

- We saw certificates to evidence that staff had completed decontamination training. To further improve staff knowledge in this area we advised the practice to consider post graduate and/or online training
- The practice were using Isopharm books to record start and end of day checks for the autoclave machine
- We saw that the second autoclave was switched on daily and regular checks were carried out to ensure it was safe to use. Staff confirmed that this autoclave was only used if the main autoclave was to break down
- Whilst we saw that sterile instruments were bagged, we found that the dates on the bags required more consistency because we saw some bags without dates and some with wrong dates. This was fed back to all staff during the visit
- Evidence of an infection control audit was in place and was dated January 2018

We were told by staff in 2016 that they had plans to develop a new decontamination room. However, during our follow up, staff told us that the planned location was unsuitable and therefore the short timescale recommended for the development of the decontamination room had not been met.

Improvement needed

Bagged sterile instruments need to be checked to ensure dates are consistent and include the date of sterilisation and a use by date.

Medicines management

A resuscitation policy was in place and in line with the Resuscitation UK guidelines.

We saw that all emergency equipment was checked regularly to ensure the dates on the equipment had not expired. A checklist was used to evidence these checks were taking place.

The practice had a named appointed first aider and a certificate was available to evidence their training. We recommended that the practice consider having other staff trained to ensure first aid can be provided at all times.

Medical devices, equipment and diagnostic systems

Recommendations made in 2016 to ensure that radiograph (X-ray) practice was in line with current legislation and guidance had all been documented as complete on the practice's improvement plan. We reviewed the actions and found:

- The radiation protection file was up to date and included all the relevant information
- Of the patient records we reviewed, we saw that x-rays were being justified in patient notes, including clinical findings being noted
- Radiographic use had increased in line with current guidelines
- Radiographic audits were being undertaken which included the quality grading of x-rays
- The controlled areas were clearly identified within the surgery. We advised the practice to consider having dose meters on the machines

The recommendations made in 2016 regarding clinical areas needing to be fit for purpose, clean and hygienic were reviewed on the follow up visit. We found the Velopex (x-ray developing machine) had been removed and was no longer on the premises. Surgery 1 and 2 were in good condition, both clean with flooring and work surfaces sealed at their edges which permits efficient cleaning. We saw that the drawers containing dental material and equipment were clean and generally well organised. Some areas, specifically the worktops in surgery 1 appeared cluttered. This was discussed with staff at the time of the visit and we recommended that the surgery is reviewed and clutter removed to uphold a clean, tidy and fit for purpose surgery.

We observed in surgery 3, old cabinets, some with missing door fronts. This was the same in 2016. However, staff confirmed that surgery 3 was not in use at the time of our visit and hadn't been since 2016. We advised that if there were future plans to use surgery 3 for clinical purposes, the environment would require attention to ensure clinical facilities were fit for purpose.

Improvement needed

Surgery 1 to be reviewed, specifically to minimise the clutter.

Safe and clinically effective care

We reviewed the materials being stored and used within the practice and found they were suitable for use because they had not passed their expiry date. Discussions with staff confirmed that materials were being checked on a regular basis but there was no evidence that these checks were carried out. Therefore, we recommended that this process is documented to evidence that checks are being carried out and that materials are suitable for use.

Our review of the employee files confirmed that all staff had received appropriate vaccinations and evidence of immunisation records were kept on staff files.

We saw evidence that the legionella risk assessment had been completed in September 2016. Staff confirmed that weekly checks were undertaken and we saw evidence of these.

Improvement needed

A system is required to evidence that checks are being carried out to ensure materials are fit for purpose and within their use by date.

Records management

We reviewed five patient records and found there were improvements in the information being recorded. We saw that reasons for attendance, what was examined and evidence of treatment planning were recorded.

Of the patient records we reviewed, medical histories were not countersigned by the dentist and there were no updated medical history in the notes for each course of treatment and verbally at each appointment. This area of record keeping must be improved and evidenced clearly in patient notes.

Improvement needed

Medical histories to be countersigned by the dentist and updated in the notes for each course of treatment and verbally at each appointment.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how services review and monitor their own performance against the National Minimum Standards.

We found evidence that the practice had completed a number of recommendations made in 2016.

We saw that formalised staff meetings took place every six months. These were documented and generally focused upon a relevant service area/topic. Daily informal meetings were also held but were not documented. These, however, ensured staff were aware of the up and coming events of the day.

Staff had completed training in a number of areas and certificates were kept on file to evidence this.

What improvements we identified

Areas for improvement identified at the last inspection included the following:

Quality of Management and Leadership

- The practice needed to develop formalised staff meetings with recorded minutes.
- The practice needed to ensure that staff receive appropriate training on a regular basis in line with current legislation and guidance.

What actions the service said they would take

The service committed to take the following actions in their 2016 improvement plan:

Quality of Management and Leadership

- Biannual formal practice meetings to be held with recorded minutes
- Individual training record to be kept for each staff member in individual personnel files. Practice-wide training already takes place e.g. CPR and clinical staff usually undertake courses together

What we found on follow-up

Workforce planning, training and organisational development

Formalised staff meetings with recorded minutes were being held and conducted on a bi annual basis. The last meeting was held in January 2018 and minutes showed evidence of the discussions. Staff told us that the formal meetings tend to focus on a specific area or topic.

Informal, daily catch ups take place with the team, with discussions centred on the day's activities and tasks. These were not documented.

A review of staff files found evidence that staff were completing a programme of training. The certificates evidenced that staff had completed training in safeguarding, medical emergencies, decontamination and radiography.

There was no training matrix in place that provided an overview of when training expired. Staff said they would check the files for this information. However, consideration should be given to implementing a training matrix which would provide a central record and overview of training for all staff.

4. What next?

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 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.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

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.

5. How we conduct follow-up inspections

Follow-up inspections can be announced or unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection. In some circumstances, we will decide to undertake an announced inspection, meaning that the service will be given up to 12 weeks' notice of the inspection.

The purpose of our follow-up inspections is to see what improvements the service has made since our last inspection.

Our follow-up inspections will focus on the specific areas for improvement we identified at the last inspection. This means we will only focus on the National Minimum Standards for Independent Health Care Services in Wales relevant to these areas.

During our follow-up inspections we will consider relevant aspects of:

- Quality of patient experience
- Delivery of safe and effective care
- Management and leadership

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels. We will also highlight any outstanding areas of improvement that need to be made.

Further detail about how HIW inspects independent services can be found on our 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
No immediate concerns identified at this inspection.			

Appendix B – Improvement plan

Service: Elegant Dental Care

Date of inspection: 13 March 2018

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.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
No areas for improvement identified during this inspection.				
Delivery of safe and effective care				
The practice must review the current arrangements of staff disposing of feminine hygiene waste and arrange for appropriate waste collection.	Workplace (Health, Safety and Welfare) Regs 1992	Putting contract into place	Jayne Williams	3 months

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	The Private Dentistry (Wales) Regulations 2008, regulation 14 (6)			
Portable appliance testing (PAT) to be carried out as soon as possible and a copy of the certificate to be sent to HIW.	The Electricity at Work Regs 1989. (HSE) The Private Dentistry (Wales) Regulations 2017, regulation 22 (a) (b)	As soon as person responsible is available to carry out PAT	Jayne Williams	6 Months
Bagged sterile instruments need to be reviewed to ensure dates are consistent and include the date of sterilisation and a use by date.	The Private Dentistry (Wales) Regulations 2008, Regulation 14 (1)(d); 14	To re-bag instruments	Lucy Lloyd	Already Completed

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	(3)(b); 14(4) WHTM (01-05) GDC Standards 1.5.1			
Surgery 1 to be reviewed, specifically to minimise the clutter.	The Private Dentistry (Wales) Regulations 2017, regulation 22 (2) (a)	To get rid of clutter	Lucy Lloyd	Already completed
A system is required to evidence that checks are being carried out to ensure materials are fit for purpose and within their use by date.	The Private Dentistry (Wales) Regulations 2017, Regulation 13 (4) (a) GDC Standards	To log every material used and expiry date.	Jayne Williams	6 months

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
	1.5.1			
Medical histories to be countersigned by the dentist and updated in the notes for each course of treatment and verbally at each appointment.	The Private Dentistry (Wales) Regulations 2017, Regulation 20 (1) (a) (i) (ii)	To document on patient record card and on computer	Sarah Chamberlain	Already completed
Quality of management and leadership				
No areas for improvement identified during this inspection.				

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):

Job role:

Date: