Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Belgrave Dental Centre

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Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Belgrave Dental Centre as part of its programme of assurance work. The practice offers a range of NHS and private dental treatments.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Care Standards Act 2000, Independent Health Care (Wales) Regulations 2011 and other relevant regulations. Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality Checks are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the registered manager and practice manager on 29 March 2021 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- What changes have you implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How are you ensuring that all patients (including vulnerable/at risk groups) are able to access services appropriately and safely?
- How has the practice and the services it provides adapted during this period of COVID-19?

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients and staff. We reviewed recent risk assessments and incident reviews and questioned the setting on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

We were told of the changes that had been made to the practice environment as a result of the pandemic. The workforce was separated into two teams (upstairs and downstairs) to avoid unnecessary contact between staff and to keep teams the same to maintain services. Personal Protective Equipment (PPE) for staff and patients is available as well as hand sanitizing stations throughout the practice. Cleaning schedules had been amended to enable more frequent cleaning. We were told that the practice were following the guidance issued within the Standard Operating Procedure for the dental management of non-COVID-19 patients in Wales.

We were told of the changes made to the environment to minimise the risk of COVID-19 transmission within the communal areas and treatment rooms. These included social distancing measures and only patients with pre-arranged appointments could visit the practice. Furniture and seating had been removed from the waiting areas. Treatment rooms had been stripped of all unnecessary items and essential objects including computer screens have been covered with wipeable plastic covers.

When patients arrive for appointments they are asked to wait in their cars or outside until a member of staff instructed them to enter. Temperature checks are taken, a new face mask provided and hand sanitizer given upon entry into the practice. We were informed that a one way system is in place throughout the building and staff use walkie talkies to communicate to others the whereabouts of patients and staff to ensure walkways stay clear.

We were told that COVID-19 risk assessments had been completed for all staff. Depending on the outcome of the assessment, the practice would determine if the staff member needed to shield[1] or undertake a different role within the practice.

We were told that three surgeries were equipped to perform Aerosol Generating Procedures (AGP)[2]. Mechanical ventilation had been installed in two surgeries to facilitate the removal of contaminated air, with the current work to mechanically ventilate the other three surgeries to be completed imminently. With regards to the non-mechanically ventilated AGP

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

surgery, patients requiring AGP treatments were given appointments near lunchtime and the end of the day so that additional cleaning could be carried out with minimal disruptions to appointment times.

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

We saw evidence of a COVID-19 specific risk assessment which had been completed in February 2021. Areas of concern have action points to mitigate the issues raised.

The following areas for improvement were identified:

We saw evidence of a general environment risk assessment, however this document was not dated. We recommend that the document is dated to clearly record when the assessment was carried out.

Infection prevention and control

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

The following positive evidence was received:

We were provided with the policies and procedures in place for the prevention and control of infection, which included their COVID-19 handbook. We saw evidence of Infection Prevention and Control (IPC) audits, together with practice cleaning schedules and records for the decontamination of instruments and dental equipment.

We were told of the systems in place to ensure all staff were aware of, and discharged their responsibilities for preventing and controlling infection. This was evidenced in a number of policies which set out the actions and responsibilities of management and staff in order to prevent the spread of the virus. In addition, we were told that PPE training, including mask training and donning and doffing[3] of PPE had been delivered to all staff.

We were told that when AGP procedures are being carried out, the triage[4] call helps identify

[3] Donning – putting on personal protective equipment (PPE); Doffing – taking off personal protective equipment (PPE)
[4] Triage is the prioritisation of patient care based on illness/injury, severity, prognosis and resource availability

the equipment that will be required. This is prepared in advance to minimise staff entering or leaving the surgery during the procedure. Staff told us that a buddy nurse is also on duty during these procedures. They escort patients to and from the surgery and also ensure surgery doors are displayed with do not enter signs when in use. These practises ensure that infection risk is minimised during AGP procedures.

We were told that staff at the practice had received COVID-19 vaccinations, with all staff having received both the doses required.

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

The practice stated they had sufficient stock of PPE and that weekly stock checks are undertaken. Required stock is documented on a white board and once ordered and received at the practice, it is removed from the board.

The following areas for improvement were identified:

We were provided with copies of the upstairs and downstairs surgery mask cleaning logs. Some of the dates entered onto the logs had the wrong year recorded. Therefore it was recommended that these logs are checked to ensure data is accurately recorded.

Governance

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

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

The following positive evidence was received:

We saw evidence of training records, which showed compliance with mandatory training. Staff also explained the process for ensuring training was up to date. In the absence of face to face training, staff continued to use e-learning[5] packages for Continued Professional Development (CPD). In addition, staff at the practice filmed their own training videos which included AGP cleaning. The videos were shared among the staff group to ensure skills and knowledge were up to date. We were told that cardiopulmonary resuscitation (CPR) training had been arranged

[5] Learning conducted via electronic media, typically on the internet.

and would be delivered in small group sessions of staff to allow for social distancing.

We were told that, in accordance with Welsh Government guidelines, the practice remained open during the initial stages of the pandemic. It was one of the first practices in the Swansea Bay health board area to commence AGPs, when the health board made the practice an urgent AGP centre. The practice did operate on a reduced workforce during this time. Throughout the pandemic the practice has maintained a system of taking calls for remote triage[6] by a clinician. This ensures patient care can be delivered according to their needs.

The practice has maintained their processes for the reporting of any incidents, with the principal dentist and practice manager having an oversight of any incidents. We were told that staff were aware of their roles and responsibilities in reporting incidents to regulatory agencies including Healthcare Inspectorate Wales (HIW). Any updated guidance for healthcare professionals was delivered in regular staff meetings, via their social media group, emails and video calls.

The process of checking emergency equipment and medicines was explained. One member of staff has responsibility for performing the weekly checks and recording the findings in the appropriate logs. Risk assessments are completed and PPE used if an external contractor is required to attend the practice.

We reviewed the Statement of Purpose[7] and Patient Information Leaflet[8], which contained all required information.

No improvements were identified.

[6] The assignment of degrees of urgency to decide the order of treatment of a number of patients.
[7] "statement of purpose" ("*datganiad o ddiben*") means the statement compiled in accordance with regulation 5(1) of the Private Dentistry (Wales) Regulations and Schedule 1.
[8] Information as required by Schedule 2 of the above regulations.

What next?

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

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Improvement plan

Setting: Belgrave Dental Centre

Date of activity: 29 March 2021

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

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

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The registered manager must review the general environment risk assessment and ensure the document is dated to clearly evidence when the assessment was completed	The Health & Care Standards – Standard 3.4 Information Governance & Communications Technology The Private Dentistry (Wales) Regulations 2017 – Regulation 16 (1) (a)	We will ensure that all future practice policy documents, including the environmental risk assessment, are dated to clearly evidence when the assessment or document was completed.	Huw Hopkins	1 month
2	The registered manager must review	The Health &	We will “pre-populate” the date	Huw Hopkins	Immediate

	the upstairs and downstairs surgery mask cleaning logs to ensure correct data is being recorded, specifically the dates when tasks have been completed	Care Standards – Standard 3.4 Information Governance & Communications Technology The Private Dentistry (Wales) Regulations 2017 – Regulation 16 (1) (a)	sections of all cleaning logs to minimise the risk of human error in date recording.		

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

Name: Huw Hopkins

Date: 13/04/2021