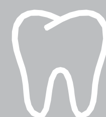
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
{my}dentist, Bargoed
Activity date: 14 September 2021

Publication date: 19 October 2021



This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-80391-088-8

© Crown copyright 2021

Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of {my}dentist Bargoed as part of its programme of assurance work. The practice provides a range of NHS and private treatments and forms part of the dental services provided within the area serviced by Aneurin Bevan University Health Board.

HIW's quality checks form part of a new tailored approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Private Dentistry (Wales) Regulations 2017(and other relevant regulations and standards). 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 services. 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 assurance and inspections can be found here.

We spoke to the registered manager[1] and a regulatory officer on 14 September 2021, who provided us with information and evidence about their service. 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 do you meet the needs of Welsh speaking patients when accessing healthcare services in the medium of Welsh?
- How has the practice and the services it provides adapted during this period of COVID-19?
- How do you ensure that equality and a rights based approach are embedded across the service?

[1] "registered manager" means a person who is registered under Part 2 of the Private Dentistry (Wales) Regulations 2017 as the manager of a private dental practice.

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- The most recent environment health and safety risk assessment action plan
- The most recent fire safety risk assessment action plan.

We also questioned the service representatives 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:

The registered manager provided details of the changes that have been made to the practice to enable patients to be seen safely throughout the pandemic. In order to protect staff and patients within the practice, the front door is locked to prevent individuals from entering the building unattended and/or without an appointment. All patients must pre-book an appointment with a dentist before attending the practice.

On arrival, patients are welcomed into the practice by a staff member and then escorted to the waiting area. The waiting area has been reorganised to allow for social distancing and no more than three patients are permitted to wait inside the practice at one time. Patients are then chaperoned to and from the surgery for their appointment. The registered manager confirmed that stickers are displayed on the floor throughout the practice to remind individuals of the two metre distance.

We were informed that clear plastic screens have been installed within the reception area to protect staff and patients. Additionally, hand sanitiser facilities are available throughout the practice.

The registered manager explained that efforts had been made to ensure that all patients have been routinely updated on the changes which have been implemented in the practice and to ensure that they individuals were aware that they could access the service if required throughout the pandemic. Additionally, we were informed that following the booking of an appointment, information is shared with the patient regarding the arrangements in place at the practice, to ensure they know what to expect when they arrive.

We were provided with copies of the practice's health and safety and fire safety risk assessment action plan documents. These documents listed the area of concern, existing control measure and action required. We were informed that full risk assessments were completed every five years, with reviews of the assessment and associated actions plans

undertaken on an annual basis. Following review of the health and safety assessment action plan, it was highlighted that there was one outstanding action in regards to a damaged dental chair in one surgery within the practice. However, the registered manager confirmed that this chair had now been replaced.

The following areas for improvement were identified:

Following review of the fire safety risk assessment action plan, it was highlighted that there was an outstanding action relating to inadequate lighting and unstable flooring within the practice cellar, hindering access to gas inlets. The registered manager confirmed that the lighting issue within the cellar had now been resolved, however, we were informed that the flooring issue was ongoing and had not been resolved. Therefore, the registered provided is required to provide HIW with assurances that the required remedial action is going to be undertaken as soon as possible to address the issue identified.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- A copy of the most recent WHTM01-05 decontamination audit and the action plan to address any areas for improvement
- Generic infection control policies and Covid-19 specific policies
- Most recent infection control risk assessments / audits
- Cleaning schedules including autoclave and ultrasonic checks.

The following positive evidence was received:

The registered manager described the processes in place to minimise the infection risk to staff and patients when aerosol generating procedures (AGP)[2] were being carried out within the practice. These arrangements were also set out in the Standard Operating Procedure (SOP). We were informed that an air filtration device has been installed which means that fallow time[3] following treatment is 10 minutes. Following the fallow time, staff then re-enter the surgery to undertake the required cleaning of the room.

Evidence was provided of a COVID-19 risk assessment in place. This document set out the risks and control measures in place for the relevant areas of the practice. The registered

[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.
[3] Fallow time is the downtime in the surgery following an aerosol generating procedure (AGP) taking place.

manager explained that this document has been reviewed as and when required throughout the pandemic. We were informed that all staff have to sign to confirm that they have read and understood the document and that staff are informed when any updates are made.

The arrangements in place to ensure that patients were routinely screened for COVID-19 symptoms prior to their appointment were discussed. We were informed that the practice previously contacted patients via telephone 24 hours prior to their appointment, to undertake the telephone screening. However, the registered manager explained that electronic pre-screening forms are now sent out to patients to complete in advance of their appointment via text or email. Arrangements were in place to check if the patient had completed the form as requested prior to their appointment; if it is identified that they have not, the patient is contacted via telephone to complete the pre-screening.

The registered manager confirmed that pre-screening calls are completed by reception staff and that training had been provided. Additionally, we were informed that pre-screening questions were available in the reception area of the practice for staff to refer to. Information obtained as part of the screening process is recorded in the patients' notes.

We were informed that should a patient notify staff that they have tested positive or are awaiting results of a COVID-19 test, they would be asked to reschedule their appointment or, if urgent, the patient would be signposted to one of the health board's Urgent Dental Centres (UDC).

The registered manager confirmed that all practice staff now have access to lateral flow tests and are required to complete a test twice a week. Additionally, we were informed that individual COVID-19 risk assessments were in places for all staff working within the practice.

Evidence of the completed Welsh Health Technical Memorandum (WHTM) 01-05[4] decontamination audit and action plan to address any issues was provided. Additionally, copies of the cleaning policy and completed surgery checklists were provided, as well as daily check records for each autoclave and ultrasonic bath.

The registered manager confirmed that one of the nurses working within the practice was the designated IPC lead and responsible for providing advice and support to other staff, as well as completing audits and spot checks to ensure IPC requirements are being adhered to by staff.

We were informed that all staff are required to complete mandatory IPC training. Training and guidance information has also been provided to ensure that staff are confident and competent in regards to personal and protective equipment (PPE) requirements, including

[4] Scope, status and structure of WHTM 01-05 Welsh Health Technical Memorandum (WHTM) 01-05 is intended to progressively raise the quality of decontamination work in primary care dental services by covering the decontamination of reusable instruments within dental facilities.

‘donning and doffing[5]’. The registered manager confirmed that all relevant staff members have been fit tested for the required PPE. Additionally, arrangements were in place to ensure that there was sufficient PPE available to staff; weekly stock checks are completed and submitted to the corporate team within head office, who are responsible for ordering new stock as and when required.

No areas for improvements were identified.

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored whether management arrangements ensure that staff are suitable in their roles and are appropriately trained in order to provide safe and effective care.

The key documents we reviewed included:

- Informed consent policies / procedures
- Escalation policies
- Business continuity plans
- Mandatory training records for all staff
- Risk assessments undertaken in relation to infection prevention and control, environment and staff health and safety
- Record card information
- Ionising Radiation (Medical Exposures)Regulations (IR(ME)R) audit
- Copy of the latest statement of purpose[6]
- Copy of the latest patient information leaflet[7].

The following positive evidence was received:

The registered manager confirmed that the practice had remained open throughout the pandemic and, as previously detailed, efforts were made to ensure that all patients were made aware that they could still access the service if required.

[5] Donning - putting on personal protective equipment (PPE); Doffing - taking off personal protective equipment (PPE)

[6] The statement of purpose is the information required in accordance with Schedule 1 to the Private Dentistry (Wales) Regulations. This includes the practice aims and objectives and the names and qualifications of the dentists and dental staff. Additionally is should list the kinds of treatment, facilities and all other services provided in or for the purposes of the private dental practice, including details of the range of needs which those services are intended to meet.

[7] The patient information leaflet is supplied to patients and includes the information required by Schedule 2 to the above regulations. The information included a summary of the statement of purpose, arrangements seeking patients’ views, access to the premises and keeping appointments.

A copy of the statement of purpose and patient information leaflet which included relevant information about the services being offered was provided as evidence. We were informed that the statement of purpose is reviewed on an annual basis. However, this did not reflect the review date information detailed within the document. The registered manager should ensure that the review date information within the statement of purpose is routinely updated to record when the document is reviewed.

A sample of policies and procedures in place were provided. We were informed that all policies are managed centrally within the organisation; they are drafted and reviewed by relevant teams and circulated to each practice. We were told that changes are shared and discussed with practice managers before being circulated to practice staff. Arrangements were in place to monitor and provide notifications in regards to scheduled review dates for all policies and procedures in current operation. The registered manager also confirmed that practice staff have access to all the policies and procedures in place.

We were informed that arrangements were implemented, from the outset of the pandemic, to allow the corporate team within the organisation to routinely share key information and advice, which included daily drop-in calls with all practice managers. Additionally, we were informed that arrangements were in place to ensure that practice staff have routinely been kept up to date with changes to guidance and the procedures in place, as and when required.

The registered manager confirmed that a system was in place to ensure that there was adequate staffing levels for each day within the practice. We were informed that staffing rota information must be uploaded onto the mapping system five weeks in advance. This information is monitored by the service area manager to highlight any issues. Additionally, the registered manager confirmed that should any issues be highlighted in regards to staffing levels, support could be sought from the area manager or via the practice manager area online group chat which had been set up.

We were informed that arrangements were in place to ensure that regular checks of the emergency equipment and medication stored within the practice took place. We were also informed that expiry dates of medication are monitored via the company internal governance system.

The registered manager confirmed that translation support was available for patients wishing to converse in Welsh via the health board. We were also informed that there were bilingual posters and leaflets available within the practice.

We were informed that the practice's responsible individual completed their visits on 29 July and 1 September 2021. The associated report following the visits was being drafted. These visits relates to the regulation 23 within The Private Dentistry (Wales) Regulations 2017, to assess the quality of service being provided against regulations and relevant standards. Following the completion of the report, it must subsequently be submitted to the registered manager and HIW.

The following areas for improvement were identified:

We were informed that a system was in place to ensure that mandatory training compliance is regularly monitored by the registered manager and at corporate level within the organisation. A copy of the mandatory training compliance document was provided as evidence, which detailed that the majority of staff had completed the training required. However, following review of the information it was highlighted that some staff were not up to date with the mandatory training requirements, which included Equality and Diversity and Information Governance. Therefore, the registered provided is required to ensure that all staff are fully compliant with all relevant mandatory training.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- 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 areas for improvements 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 the areas for improvements 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.

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

Improvement plan

Setting: {my}dentist Bargoed

Date of activity: 14 September 2021

The table below includes improvements identified during the 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 provider must ensure that the required remedial action is undertaken in regards to concerns highlighted around the cellar flooring within the building.	Regulations 22(2)(b) 22(4)(a) of the Private Dentistry (Wales) Regulations Health and Care Standards, Standard 2.1 Managing Risk and Promoting	Contractors attended practice 21/09/2021 to repair the uneven floor which is now safe to walk on. The outstanding action on the risk assessment is now deemed as completed		Completed

		Health and Safety			
2	The registered provided is required to ensure that all staff are fully compliant with all relevant mandatory training.	Private Dentistry Regulations (Wales) 2017 17(3)(a) Health and Care Standards, Standard 7.1 Workforce	A 1-2-1 discussion has been held with 4 staff members where they have been given a deadline of Monday 4th October to complete all relevant training and provide certificates as evidence. Failing to provide the mandatory training certificates will result in escalation to the clinical support manager and area development manager	Practice Manager	04/10/2021

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: Natalie Watson

Date: 27/09/2021