Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
Cwmdulais Dental Centre
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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@gov.wales

Website: www.hiw.org.uk

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Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Cwmdulais Dental Centre as part of its programme of assurance work. The practice offers a range of NHS and private treatments and employs two dentists, a specialist orthodontist[1] and four dental nurses as well as a practice manager/receptionist.

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. 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[2] and practice manager on 14 December 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] An orthodontist is a dentist that has undergone additional specialist training in order to treat irregularities in the teeth and jaws.
[2] "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 environmental risk assessments / audits. 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 had been made to the practice environment that allowed patients to be seen during the COVID-19 pandemic. In order to protect patients and staff we were told that the door to the practice was kept locked, ensuring that only those individuals with pre-booked appointments could enter the practice. The registered manager informed us that a sign on the door of the practice informed patients of the increased measures in place to protect against COVID-19. Patients were asked to attend wearing a face covering and would be asked to use hand sanitiser upon entry to the practice.

We were told that the practice had installed clear plastic screens at the reception desk to protect the staff and a sticker was placed in front of the reception desk reminding patients to socially distance. The registered manager informed us that toys and magazines had been removed from the waiting area. We were told that staff also discouraged patients from using this space. Instead patients would be only allowed into the practice when able to go straight through into the treatment rooms.

We asked what measures were in place to keep patients informed of the safety measures relating to COVID-19, prior to attending the practice. We were told that staff would telephone patients prior to their appointment and explain the procedures to follow. This also allowed the patient to ask questions if they were unsure, prior to arriving at the practice. The registered manager told us that for patients with access to email, this information was also sent through electronically. Posters were also displayed throughout the practice to remind patients of the increased measures in place and what was expected of them.

The registered manager told us about the facilities to ensure accessibility to the practice for those with disabilities. We were informed that there was a hearing loop[3] system to assist those patients that may be hard of hearing. In addition, the practice had access to a telephone based translation service provided by the local health board for patients where English was not their first language. Furthermore, the registered manager informed us that

[3] A **hearing loop** (sometimes called an audio induction loop) is a special type of sound system for use by people with hearing aids.

they were fluent in four different languages. For those patients with accessibility difficulties the surgery had a downstairs treatment room and an accessible toilet. Doorways and corridors had also been widened to promote accessibility for patients in wheelchairs. We were told that the practice had purchased the land opposite the practice which could be used for patient parking.

We were told that patients were encouraged to communicate through the medium of Welsh. The practice had a Welsh speaking member of staff and all information was available in both English and Welsh.

We saw evidence of risk assessments for all practice areas. These documents listed various risks, control measures and precautions that were in place to mitigate the highlighted risks and demonstrated a safe practice environment.

No areas for improvements were identified.

Infection prevention and control (IPC)

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 WHTM 01-05 decontamination audit and the action plan to address any areas for improvement.
- Generic infection control policies and Covid-19 specific policies
- Cleaning schedules.

The following positive evidence was received:

The practice manager confirmed the processes in place to protect patients and staff when an aerosol generating procedure (AGP)[4] was taking place. This process followed the most recent guidance issued by the Chief Dental Officer (CDO) for Wales. All staff were kept informed of the guidance issued by the CDO and associated practice policies and procedures via regular staff meetings. Staff not in work when staff meetings took place were encouraged to join via video call. The practice also used a mobile messaging application to keep staff up to date on changes to guidance.

The registered manager informed us that they had allocated specific surgeries to provide AGP

[4] 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.

and non-AGP procedures. We saw evidence provided in the practice Standard Operating Procedure (SOP) that during an AGP procedure, high volume suction[5] and rubber dam[6] would be used where possible to lessen the risk of airborne particles (aerosols)[7]. We were told that surgeries had been cleared of all unnecessary equipment and any materials not required for a particular treatment would remain in drawers that would not be opened. We were told that computers had been removed from the treatment areas and clinicians would type up their notes contemporaneously in a spare surgery.

We were told that fixed air filtration units and air purifiers had been installed into the surgeries which enabled the practice to operate with the minimum fallow time[8] of 10 minutes following an AGP and the registered manager informed us that all staff had been trained in their correct use. In addition, windows would remain open and a sign was placed on the door of the surgery advising staff that an AGP had taken place and not to enter until the fallow time had finished.

We confirmed with the registered manager the process to check that patients attending the practice were not displaying symptoms of COVID-19. We were informed that patients would be telephoned before their appointment and asked a series of screening questions related to COVID-19 and to update and confirm their medical history. Patients would then be rescreened on attendance at the practice. Any patient that reported displaying symptoms of COVID-19 would be discouraged from attending. The registered manager confirmed that the practice had a SOP in place so that patients with the symptoms of COVID-19 could be seen safely.

The registered manager informed us that all staff undertaking AGP's had been correctly fit-tested for filtering-face-piece masks (FFP3[9]) and were up-to-date with training in the use of enhanced personal protective equipment (PPE), including the correct method of donning and doffing[10]. This was achieved through training videos available online and further reinforced by posters placed in prominent positions within donning and doffing areas.

We asked the registered manager to describe their experience of sourcing PPE during the pandemic. The practice manager informed us that a stock check would be undertaken by them on a weekly basis. We were told that the practice had not experienced any difficulties in ensuring they had an adequate supply of PPE items and had been supported by the local health board where necessary.

[5] A High Volume Evacuator (HVE) is a suction device that draws a large volume of air over a period of time.
[6] A rubber dam or dental dam is a thin sheet of latex or latex-free material. It is used to isolate teeth from the rest of the mouth during a dental procedure to improve the success of tooth repairs.
[7] Dental aerosols can carry viruses and transmit infection.
[8] Fallow time is the downtime in the surgery following an aerosol generating procedure (AGP) taking place which allows any droplets to settle before cleaning and decontamination takes place
[9] The need for FFP3 Mask (oral nasal disposable mask respiratory protection) to be worn is identified through clinical risk assessment. The mask is used to protect against respiratory borne pathogens. To use these masks, relevant staff must be 'face fit tested' to ensure that they can achieve a suitable face fit of the mask and that it operates at the required efficiency.
[10] Donning – putting on personal protective equipment (PPE); Doffing – taking off personal protective equipment (PPE)

We saw evidence of an up to date COVID-19 policy that was version controlled, dated and in line with up-to-date guidance, as well as up to date written procedures for the prevention of COVID-19 that were in line with current guidelines. We were also provided with an infection control policy document that covered all areas and recently completed and compliant infection control audits and daily checklists for decontamination and sterilisation equipment. We were also provided with a cleaning schedule for all surgeries that that took into account the increased measures due to the COVID-19 pandemic.

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
- 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.

The following positive evidence was received:

The registered manager informed us that the practice did not close during the pandemic and continued to provide support and advice to patients who required it, via telephone. Patients who required prescription only medication were able to access it via remote prescribing. We were told that at the start of the pandemic, staff were split into “bubbles” of staff with each staff bubble working only at set times, this helped to keep staff safe and the practice operational. The registered manager made us aware of notable good practice by informing us that at the start of the pandemic the practice had employed the use of a video messaging application in order to assess patients via video call.

The registered manager spoke very highly of the staff, telling us that they had worked hard to support each other, the practice and the patients. We were told that all staff were well supported by the registered manager and practice manager and had undertaken COVID-19 risk assessments to ensure they were kept safe in their work. Staff were instructed to undergo

twice weekly lateral flow tests[11] and any that displayed symptoms of COVID-19 were told to self-isolate and obtain a Polymerase Chain Reaction (PCR)[12] test.

We were informed that the practice had a robust audit process in place and we were provided with an example covering record keeping and COVID-19 compliance that demonstrated good results. The registered manager told us that audit processes had continued, despite the pandemic, and the results of these were regularly discussed with staff to ensure continuing improvement.

We asked the practice managers to describe the processes and procedures that ensured emergency drugs and equipment were present and in date. We were told that the emergency drugs and equipment were checked and logged weekly by two dedicated members of staff. Most emergency equipment was located in a room accessible to all staff in an emergency. Emergency glucagon[13] was located in a fridge dedicated for clinical use only that was temperature controlled and the practice defibrillator was stored behind the reception area.

The following areas for improvement were identified:

As part of the quality check process, the registered manager submitted to HIW evidence of mandatory training for all staff. At the time of the quality check, many staff were not compliant with requirements for fire training and training in Ionising Radiation (Medical Exposure) Regulations[14] (IR(ME)R). Furthermore, evidence indicated that some staff did not appear to have completed up to date training in basic life support (BLS) or in child protection or training in the Protection of Vulnerable Adults. It is important that all staff are up to date with their knowledge and skills in relation to their responsibilities and role within a clinical setting in order to protect patients and staff.

The registered manager must ensure that all staff are fully up to date with mandatory training requirements and inform HIW when staff have completed their mandatory training.

The evidence provided to HIW in support of the mandatory training further indicated that the registered manager did not have an effective system for monitoring staff compliance with mandatory training. Neither was there a system to monitor the requirements that fell under this responsibility as per the Private Dentistry (Wales) Regulations 2017. This was evidenced when the request for the prompt provision for further evidence in support of mandatory training requirements for staff had not been met. This meant that staff may be working

[11] A Lateral Flow Test is a test undertaken at home using swabs taken from the nose and/or throat to provide a rapid indication of the presence of COVID-19. A positive test will require the user to undergo a PCR test and to self-isolate.
[12] A "polymerase Chain Reaction" ("PCR") test is used to determine whether an individual is infected with the COVID-19 virus.
[13] "Glucagon" is an emergency drug administered via intramuscular injection in the event of diabetic hypoglycaemia.
[14] Ionising Radiation (Medical Exposure) Regulations 2017 training relates to the training and continuous professional development of healthcare staff that are responsible for the taking or processing of images captured by x-ray. This training ensure that staff are up to date with best practice and guidance relating to the use of x-rays and/or the equipment used within a healthcare setting.

without up to date knowledge in key areas related to their role, leading to the potential for patient harm.

The registered manager must have an effective system in place to monitor staff compliance with mandatory training. This is to ensure that staff maintain up to date knowledge and skills in areas such as BLS, fire awareness, the protection of children and vulnerable adults, IR(ME)R requirements and infection prevention and control.

During the quality check process we were informed that certain members of staff whom were discovered to be lacking in areas of mandatory training had been newly appointed. The registered manager indicated that she believed that these members of staff had in fact completed elements of mandatory training as part of previous employment.

The registered manager must ensure that satisfactory evidence is of prior staff training before commencement of employment within the dental practice. Areas of non-compliance with training must be rectified at the earliest opportunity and as part of the staff induction within the practice.

During the quality check we requested evidence of the most recent radiography audit completed by the practice. This was provided to us at a later date following request by the inspector. It is a requirement under the IR(ME)R 2017 that regular auditing is carried out. This is to ensure that operators of radiography equipment and the equipment used for this purpose are meeting acceptable criteria and to identify any training needs or equipment maintenance.

Upon review of the radiography audit provided it was noted that it had not been dated and did not contain details of the clinician(s) whom had been audited. In addition, no date had been set to repeat the audit and no conclusion or action plan had been raised to encourage continued improvement where necessary. This means that individual training needs may not be identified and addressed in a timely manner and re-audit may not be completed in an appropriate time frame.

The registered manager must ensure that the radiography audit:

- Is appropriately dated, assessed and accompanied by a suitable action plan when required to encourage improvements
- Repeated regularly as dictated by the IR(ME)R 2017 and sooner if indicated by audit outcomes

As part of the quality check HIW reviewed the statement of purpose and patient information leaflet provided by the practice as part of the evidence requested. These are documents prepared under regulation 5 and regulation 6 respectively of the Private Dentistry (Wales) Regulations 2017 and describe the manner in which the private dental practice will operate. The patient information leaflet is intended to provide patients with a guide about the practice and contains details of treatments provided, registered dental professionals that work at the

practice as well as their qualifications and details of how to provide positive feedback or how to make a complaint to the relevant bodies if necessary. However, it was noted that some of the information contained within these documents was no longer accurate and required updating. This included the incorrect details for the local health board area.

The registered manager must update the statement of purpose and patient information leaflet to include the correct details for the health board area and provide these documents to HIW once updated.

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:	Cwmdulais Dental Centre
Health Board:	Swansea Bay University Health Board
Date of activity:	14 December 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.

	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The registered manager must ensure that all staff are fully up to date with mandatory training requirements and inform HIW when staff have completed their mandatory training.	Regulation 17 (3)(a)(b) of The Private Dentistry (Wales) Regulations 2017	The registered manager will review staff training every 3 months. A comprehensive and detailed report will be held within practice. With this information the practice will be able to update HIW with details of mandatory training.	Dr Carla Queiros	Maximum 3 months
2	The registered manager must have an effective system in place to monitor staff compliance with mandatory training. This is to ensure that staff	Regulation 17(1)(a) and Regulation 8(1)(i) of The	A comprehensive and detailed report will be held within practice and reviewed every 12 weeks. We aim to fully complete all mandatory staff training as quickly	Dr Carla Queiros	Maximum 3 months

	maintain up to date knowledge and skills in areas such as BLS, fire awareness, the protection of children and vulnerable adults, IR(ME)R requirements and infection prevention and control.	Private Dentistry (Wales) Regulations 2017	and efficiently as possible. It is essential that all staff are up to date with training. The practice is dedicated in providing support to all our staff.		
3	The registered manager must ensure that satisfactory evidence is obtained of prior staff training before commencement of employment within the dental practice. Areas of non-compliance with training must be rectified at the earliest opportunity and as part of the staff induction within the practice.	Regulation 18 (2)(c) of The Private Dentistry (Wales) Regulations 2017	A new detailed staff induction has now been put in place within practice, highlighting training needs. As a practice we aim to provide new employees with a detailed training plan if there are any gaps within their mandatory CPD.	Dr Carla Queiros	Immediately.
4	The registered manager must ensure that the radiography audit: • Is appropriately dated, assessed and accompanied by a suitable action plan when required to encourage improvements • Repeated regularly as dictated by the IR(ME)R 2017 and sooner if indicated by audit outcomes	Regulation 8 (1)(n) of The Private Dentistry (Wales) Regulations 2017	The radiography audit was sent to HIW incomplete. The audit will be reassessed and sent through with all mandatory details with a suitable action plan attached. As a practice radiography audits will be repeated on a regular basis as stipulated within IRMER guidelines. Audits will be closely monitored and if necessary repeated before the recommended time.	Dr Carla Queiros	ASAP

5	The registered manager must update the statement of purpose and patient information leaflet to include the correct details for the health board area and provide these documents to HIW once updated.	Regulation 5 and Regulation 6 of The Private Dentistry (Wales) Regulations 2017	All relevant paperwork has been updated	Sue Morgan	Immediately

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: Dr Carla Queiros

Date: 17th January 2022