

**General Dental Practice
Inspection (Announced)**
Betsi Cadwaladr University
Health Board
Llangefni Dental Practice

09 February 2015

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1. Introduction

Healthcare Inspectorate Wales (HIW) completed an announced inspection to Llangefni Dental Practice at 57 High Street, Llangefni, Anglesey, LL77 7NA within the area served by Betsi Cadwaladr University Health Board on 9th February 2015.

During the inspection we considered and reviewed the following areas:

- Patient experience
- Delivery of Standards for Health Services in Wales
- Management and leadership
- Quality of environment.

2. Methodology

HIW inspections of General Dental Practices seek to establish how well practices meet the standards in *Doing Well, Doing Better: Standards for Health Services in Wales*¹.

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

- Information held by HIW
- Interviews of staff including dentists and administrative staff
- Conversations with nursing staff
- Examination of a sample of patient medical records
- Examination of practice policies and procedures
- Examination of equipment and premises

¹ Doing Well, Doing Better: Standards for Health Services in Wales came into force from 1st April 2010. The framework of standards sets out the requirements of what is expected of all health services in all settings in Wales. www.weds.wales.nhs.uk/opendoc/214438

- Information within the practice information leaflet and website
- HIW patient questionnaires

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

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

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

3. Context

Llangefni Dental Practice (known in Welsh as Deintyddfa Llangefni) provides services to approximately 3,000 patients in the Llangefni and surrounding area of Anglesey. The practice forms part of dental services provided within the geographical area known as Betsi Cadwaladr University Health Board.

In September 2014 the practice was acquired by IDH (Integrated Dental Holdings). IDH's website information² states that IDH is Europe's largest dental corporate company and has a network of over 600 dental practices nationwide, looking after the needs of over 10 million patients. IDH has a growing number of NHS practices in England, Scotland and Wales.

Llangefni Dental Practice includes a staff team of two dentists; two dental nurses, a receptionist and a practice manager. The practice provides a range of services to NHS and private patients but, at the time of our inspection, no written information was available regarding these.

Any dentist working at the practice who is also registered with HIW to provide private dentistry will also be subject to the provisions of The Private Dentistry (Wales) Regulations 2008 and the Private Dentistry (Wales) (Amendment) Regulations 2011.

² <http://idhgroup.co.uk/>

4. Summary

HIW explored how Llangefni Dental Practice meets the standards of care in the Doing Well, Doing Better: Standards for Health Services in Wales.

All of the eight patients who responded to HIW's questionnaire said they were satisfied with the services at Llangefni Dental Practice. The practice was taken over by IDH in September 2014 and we have recommended that patients be given access to written information as soon as possible, with consideration to patient's language and communication needs.

The standard of record keeping at the practice was excellent. We also saw that the practice had the necessary equipment, instruments, emergency medication and protective clothing for clinical practice. We were satisfied with the decontamination process, as demonstrated to us by the dental nurse. However we have recommended that the location of the extractor fan in the decontamination be reconsidered. We have also recommended that the practice seeks advice from their Radiation Protection Advisor regarding the demarcation of controlled areas.

Llangefni Dental Practice has undergone significant management changes in the last couple of years. There was evidence that staff had been very supportive to each during these transitional periods and they told us that they have a good working relationship. We have recommended that IDH support the practice manager to review and develop local procedures in line with their overarching policies and procedures and to ensure that they refer to relevant legislation, guidelines and policies in Wales.

We saw that staff were up to date with their continuous professional development programmes but we have recommended that a training matrix is maintained for this purpose.

There was evidence that the practice takes complaints seriously and that they respond to them appropriately. However a full review of the complaints policies and procedure needs to be undertaken and up to date information should be provided to patients.

Llangefni Dental Practice has limited access for people with disabilities. Although there is no dedicated car parking area, there is a public car park within close proximity. We observed that the standard of cleanliness was good. We have advised the practice to take steps to prevent the risk of patients and visitors getting burned or scalded from hot radiators.

5. Findings

Patient Experience

HIW issued a questionnaire to patients during the inspection and all of the eight patients who responded said they were satisfied with the services at Llangefni Dental Practice. The practice was taken over by IDH in September 2014 and we have recommended that patients be given access to written information as soon as possible, with consideration to patient's language and communication needs.

Eight HIW questionnaires were completed by patients during the inspection. Two of the patients had been registered with the practice for approximately 12 months and the six remaining patients said they had been registered there between 10 and 20+ years. All the patients indicated they were satisfied with the service; they said that the practice team usually makes them feel welcome and that they are given enough information about their treatment.

We spoke with one of the patients who had been registered with the same dentist for over 20 years. The patient spoke highly about the dentist and spoke of an occasion when the dentist came in on his day off to attend to his emergency appointment.

None of the patients reported that they had experienced delays in being seen by the dentists and the patient we spoke with was seen within 10 minutes of his appointment. Additional comments received by patients included that staff were *“always very obliging”* and *“very polite and courteous”*. Another patient said they were *“very happy and satisfied with Mr Thomas’ treatment and staff”*.

Four of the patients did not know how to access the out of hours’ service and two patients did not know how to make a complaint. At the time of our inspection the provision of written information at the practice was limited but we were told that IDH were producing new information, which would also be made available on their website. Of the few written notices and leaflets we saw (including charges for NHS and private dentistry services), the font was small and could not be read even from a short distance away.

Recommendation

IDH must ensure that patients have access to information about the practice as soon as possible. A range of media and formats should be considered to address the communication and language needs of patients.

As part of the above process IDH must ensure that information regarding their complaints procedure and how to access the out of hours service is included. This key information should be prominently displayed within the practice.

We were told that a high proportion of patients (which the practice manager estimated at 90%) who are registered are Welsh speaking. However all the information being provided by IDH was written in English only. The dentist and the practice manager told us that they have requested Welsh written information from IDH and will continue to follow this up.

Recommendation

IDH should produce information in the Welsh language to ensure that the communication needs of the Welsh speaking patients registered with the Llangefni practice are addressed.

There was no evidence that the practice had an established system for engaging with patients and obtaining their feedback about the service. However the practice manager had issued a survey a month prior to our visit after being advised by IDH to do this pending our inspection. We looked through the completed surveys which indicated that patients were very satisfied with the staff and treatment received. We were told IDH were keen to promote patient participation and, in fact, the practice received a stock of IDH patient feedback forms on the morning of our inspection.

Recommendation

The practice should ensure that patients are provided with various opportunities to provide feedback about the service and to be involved in the design, planning and delivery of services.

Delivery of Standards for Health Services in Wales

The written records we saw indicated that the standard of record keeping at the practice was excellent. We also saw that the practice had the necessary equipment, instruments, emergency medication and protective clothing for clinical practice.

We were satisfied with the decontamination process, as demonstrated to us by the dental nurse. However we have recommended that the location of the extractor fan in the decontamination be reconsidered. We have also recommended that the practice seeks advice from their Radiation Protection Advisor regarding the demarcation of controlled areas.

We viewed three patient records per dentist and overall we found that the standard of record keeping was excellent, providing sufficient information about patients' appointments, treatments and consent. When necessary, patients were being referred to other health professionals for specialist treatments. However there was no formal system for monitoring progress with these referrals and potentially therefore, if the referrals were not actioned, patients could get lost in the system.

Recommendation

The practice is advised to introduce a system for logging and following up any patient referral made to other health professionals.

A new computerised system had been implemented by IDH and we found that one patient's medical details had not yet been transferred onto the new system. We advised the practice to complete this as soon as possible.

We inspected the radiographic documentation and equipment and found that there were satisfactory systems in place, including valid certificates, for maintenance and quality assurance checks. Radiographs were processed digitally and we found that their quality was excellent. We saw a valid ionising training certificate for one dentist and were told that the other dentist had undertaken training in the last 12 months but had not brought a copy of the certificate to the practice. We advised the dentist to make a copy available at the practice and to forward a copy of this to HIW.

There was no evidence that the controlled areas, to alert staff of the radiation exposure, had been demarcated or delineated by the practice, as required under The Ionising Radiations Regulations 1999 (IRMER).

Recommendation

The practice must ensure that diagrammatic evidence of the controlled areas is contained in the practice's radiation protection file. We would advise the practice to seek their Radiation Protection Advisor's advice for this purpose.

The practice had appropriate resuscitation equipment and stock medication to use in the event of an emergency. All staff had received cardio pulmonary resuscitation training during April 2014 and copies of their training certificates were made available to us. Emergency medications were within their expiry date and the practice was using their computer system to monitor these and to remind them when relevant medication needed to be replaced.

There was a dedicated decontamination room and the process was demonstrated to us by one of the nurses. Whilst there was a clear system in place to process dirty and clean instruments we noticed that the extractor fan was above the clean side of the room. Where extractor fans are used, The Welsh Health Technical Memorandum (WHTM) 01-05 instructs that care should be taken to ensure that the airflow is from clean to dirty.

Recommendation

We have advised the practice to reconsider the positioning of the extractor fan to ensure that the airflow in the decontamination rooms is from clean to dirty.

Dental instruments were initially washed in an ultrasonic bath and we noticed that the plug for this piece of equipment did not have a portable appliance testing (PAT) sticker. We saw PAT documentation which confirmed that two PAT testing had been undertaken in the last 12 months, one by the previous company and one on behalf of IDH. The dentist and practice manager said they were sure that the ultrasonic bath had been tested but, for the most recent test, there was no schedule listing the equipment tested and therefore they agreed to follow this up.

Cleaning of instruments was initially being undertaken manually and ideally, as part of continuous improvement, WHTM 01-05 recommends washer disinfectors for cleaning purpose. The decontamination room contained two

type N³ autoclaves for sterilising the equipment and, in accordance with WHTM 01-05, this type is not suitable for reprocessing instruments with a lumen. These provisions should therefore be considered in the practice's future development.

Clean equipment was being stored in sealed containers and we saw that each bag contained the sterilised date and expiry date, which was good practice.

There were suitable containers for the storage and disposal of hazardous and feminine hygiene waste. We suggested however that the sanitary disposal unit in the patient toilet be moved within reach of the toilet. Although the practice had a contract for the collection of commercial waste the practice could not find a copy of it. Therefore we have requested that a copy is obtained and kept at the practice.

When we checked patients' paper notes we found that one of the paper wallets contained three root canal files that were stored in a steri pouch. The dentist and practice manager assured us that they no longer used this traditional storage method and also confirmed that they now operate a single use policy for these instruments.

³ An autoclave is a piece of equipment to sterilise dental instruments. The types of autoclaves are referred to in the Welsh Health Technical Memorandum (WHTM) 01-05.

Management and Leadership

Llangefni Dental Practice has undergone significant management changes in the last couple of years and is now being run by Integrated Dental Holdings (IDH). There was evidence that staff had been supportive to each other during these transitional periods and they told us that they have a good working relationship.

We have recommended that IDH support the practice manager to review and develop local procedures in line with their overarching policies and procedures and to ensure that they comply with the legislation, guidelines and policies in Wales.

We saw that staff were up to date with their continuous professional development programmes but we have recommended that a training matrix is maintained for this purpose.

There was evidence that the practice takes complaints seriously and that they respond to them appropriately. However a full review of the complaints policies and procedure needs to be undertaken and up to date information should be provided to patients.

Llangefni Dental Practice has undergone significant management changes in the last couple of years. The practice was owned by two of the dentists but they sold the business to Denticare during 2012. This process involved a change of employment contracts and a new set of policies and procedures. The business was then sold to IDH in September 2014, which again necessitated new contracts, policies and procedures. IDH appointed one of the existing staff members as practice manager. At the time of our inspection the practice manager was new in post and still in the process of getting used to her new role and IDH's systems.

We spoke with all four of the staff members present during the inspection, including a dentist, a dental nurse, the practice manager and receptionist. We observed a respectful working relationship between them; staff members reported that they work well together and are very supportive of each other. We saw that a disclosure and barring service check had been undertaken for all staff members.

During the inspection we saw that there was still much to do in relation to implementing and embedding IDH policies and procedures at the practice. The practice manager was still accessing policies and procedures from IDH's website and printing hard copies of these as needed. When we viewed some

of these policies, we saw that they were generic, applying to relevant legislation and policies in England, and that any differences in their Welsh equivalent had not been identified. We also saw that there were no local procedures at the Llangefni practice to supplement IDH's policies.

Some of the policy files contained previous documentation by Denticare. A few policies contained staff members' signature as evidence that they had been read and understood by them. However as these signatures were not dated the practice could not evidence whether staff had read the old versions or the new IDH policies.

Recommendation

IDH must support the practice manager to review all IDH policies and procedures to ensure that they refer to relevant Welsh legislation, policies and guidelines. Where necessary, local procedures should be developed to support IDH's overarching policies.

Key policies and procedures should be shared amongst staff and if signature sheets are used, these should include the date that they were read by individual staff members.

We discussed the practice's complaints procedures and viewed their policies. There was evidence that complaints are taken seriously by the practice and we saw sufficiently detailed logs of all concerns and complaints received; these included the outcome of each one. However, we saw that the complaints file contained policies/procedures for various organisations, including IDH, Denticare, Betsi Cadwaladr University Health Board and General Dental Council. Additionally a complaints code of conduct was displayed in the waiting room. None of these complaints procedures referred to the NHS 'Putting Things Right' arrangements, although the practice manager printed this information from the NHS website while we were there.

Recommendation

A full review of the complaints policies and procedure needs to be undertaken and information no longer relevant should be disposed. Clear procedures need to be developed and should distinguish between the complaints procedure for NHS and private patients in Wales.

The amended/updated complaints procedures should be made available to patients and be prominently displayed in the waiting room.

There was no evidence that quarterly infection control audits were being undertaken at the practice and, in line with WHTM 01-05, these should be carried out in compliance with the health board policy.

Recommendation

We have advised the practice manager to refer to WHTM 01-05 regarding infection control audits and to seek advice from the health board regarding the recommended audit tools and frequency.

We viewed a sample of training records. The most recently recruited staff members told us that the induction programme was good and they continued to be well supported by the dentists, practice manager and other team members. Staff confirmed that there are sufficient training opportunities and we saw that their files contained numerous training certificates from previous and the current year. Some of the training records were held in various files and therefore it was difficult to gain an overall picture of where staff were up to with their training requirements.

Recommendation

We would advise the practice to maintain a training matrix to include each staff member, the mandatory and specialist training received, refresher due dates and any planned training pending.

The practice manager told us that she had completed an annual appraisal for two of the staff members and that a programme had been developed to appraise the remaining staff.

Team meetings are held on a monthly basis and we saw a sample of agendas and minutes. There was evidence of a constructive and learning ethos within the practice and the team minutes provided sufficient details about the issues discussed and arising from these. The staff members confirmed that they all actively participate in discussions at these meetings.

Given the number of recommendations identified during this inspection, consideration should be given to ensuring -that there are more effective and proactive arrangements in place between IDH and the practice to monitor compliance with relevant regulations and standards.

Quality of Environment

Llangefni Dental Practice has limited access for people with disabilities. Although there is no dedicated car parking area, there is a public car park within close proximity. We observed that the standard of cleanliness was good. We have advised the practice to take steps to prevent the risk of patients and visitors getting burned or scalded from hot radiators.

The practice is conveniently located on the High Street in the market town of Llangefni. There is a step to enter the premises and a portable ramp has been obtained for people using wheelchairs.

The building has three storeys, one of which is for use by staff only. One of the surgery rooms is on the ground floor and the other surgery is on the first floor. The stairs within the building are steep but we noted that there were handrails on both sides to assist people with mobility problems. The patient toilet was located on the first floor and contained liquid soap and disposable towels to prevent any cross contamination.

There was no dedicated car parking area for patients. However there is a public car park at the back, within close proximity of the building and there is also time restricted parking to the front.

The reception/waiting room was adequately spacious for a two dentist practice and was clean and bright.

Although the heating was on we found that some areas of the practice were slightly cold. However the temperature in the waiting area was satisfactory and none of the patients raised any issues regarding the heating or temperature. The radiator in the waiting room was very hot to touch and some of the chairs in the waiting room leant against it. The radiator did not have a protective cover and potentially therefore people could accidentally burn or scald themselves.

Recommendation

The practice is advised to take steps to prevent the risk of patients and visitors getting burned or scalded from hot radiators.

We saw that fire extinguishers were located at various points within the building and that regular maintenance checks had been undertaken.

6. Next Steps

This inspection has resulted in the need for the dental practice to complete an improvement plan. The details of this can be seen within Appendix A of this report.

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

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

Appendix A

General Dental Practice: **Improvement Plan**

Practice: **Deintyddfa / Llangefni / Dental Practice**

Date of Inspection: **9th February 2015**

Page Number	Recommendation	Practice Action	Responsible Officer	Timescale
	Patient Experience			
6-7	IDH must ensure that patients have access to information about the practice as soon as possible. A range of media and formats should be considered to address the communication and language needs of patients. As part of the above process IDH must ensure that information regarding their complaints procedure and how to access the out of hours service is included. This key information should be prominently displayed within the practice. IDH should produce information in the Welsh			

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	language to ensure that the communication needs of the Welsh speaking patients registered with the Llangefni practice are addressed.			
7	The practice should ensure that patients are provided with various opportunities to provide feedback about the service and to be involved in the design, planning and delivery of services.			
	Delivery of Standards for Health Services in Wales			
8	The practice is advised to introduce a system for logging and following up any patient referral made to other health professionals.			
9	The practice must ensure that diagrammatic evidence of the controlled areas is contained in the practice's radiation protection file. We would advise the practice to seek their Radiation Protection Advisor's advice for this purpose.			
9	We have advised the practice to reconsider the positioning of the extractor fan to ensure that the airflow in the decontamination rooms is from clean to dirty.			

Page Number	Recommendation	Practice Action	Responsible Officer	Timescale
	Management and Leadership			
12	IDH must support the practice manager to review all IDH policies and procedures to ensure that they refer to relevant Welsh legislation, policies and guidelines. Where necessary, local procedures should be developed to support IDH's overarching policies. Key policies and procedures should be shared amongst staff and if signature sheets are used, these should include the date that they were read by individual staff members.			
12	A full review of the complaints policies and procedure needs to be undertaken and information no longer relevant should be disposed. Clear procedures need to be developed and should distinguish between the complaints procedure for NHS and private patients in Wales. The amended/updated complaints procedures should be made available to patients and be prominently displayed in the waiting room.			
13	We have advised the practice manager to			

Page Number	Recommendation	Practice Action	Responsible Officer	Timescale
	refer to WHTM 01-05 regarding infection control audits and to seek advice from the health board regarding the recommended audit tools and frequency.			
13	We would advise the practice to maintain a training matrix to include each staff member, the mandatory and specialist training received, refresher due dates and any planned training pending.			
	Quality of Environment			
14	The practice is advised to take steps to prevent the risk of patients and visitors getting burned or scalded from hot radiators.			

Practice Representative:

Name (print):

Title:

Signature:

Date: