Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Dental Practice Inspection Report (Announced)

Brynteg Dental practice (Carmarthen), Hywel Dda University Health Board

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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

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do.
We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Brynteg Carmarthen Dental Practice, Hywel Dda University Health Board on 30 October 2023.

Our team for the inspection comprised of a HIW Healthcare Inspector and a Dental Peer Reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. Unfortunately, none were received. We spoke to staff working at the service during our inspection.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found patients were being treated professionally, with kindness and respect. We noted improvements could be made in providing a Welsh 'Active Offer' to patients. We saw there was timely treatment of those patients requiring emergency appointments.

This is what we recommend the service can improve:

- To put arrangements in place to provide a robust 'Active Offer' to patients.

This is what the service did well:

- We saw patients being treated with kindness, dignity and respect
- The service displayed a focus on the rights and equality of patients and staff, including any reasonable adjustments required.

Delivery of Safe and Effective Care

Overall summary:
We found a clean and tidy practice although some improvement was required within the decontamination room, the safe storage of medicines and aspects of patient records. We saw that fire safety checks were complete and dental equipment was in working order. Staff told us they felt confident in the use of the equipment and were trained appropriately.

This is what we recommend the service can improve:

- The temperature, cleanliness and organisation of the decontamination room
- The safe storage and recording of medicines
- Areas of patient records required strengthening.

This is what the service did well:

- Fire safety precautions were comprehensive
- The practice environment was kept clean and tidy.

Quality of Management and Leadership

Overall summary:
We found suitable governance and leadership arrangements in place to support the effective working of the practice. We saw the process for recording and responding

to feedback and complaints was appropriate, while we noted areas for improvement with the risk assessment of missing employment information for long-standing employees. We also saw improvements needed to ensure smoking cessation audits take place routinely and that staff appraisals take place annually. We noted that staff meetings were held regularly and working relationships with other local health services were supportive.

This is what we recommend the service can improve:

- Assess the risk of missing employment information from long-standing employees
- Ensure staff appraisals take place annually.

This is what the service did well:

- We observed good working relationships within the practice and between the Brynteg Dental group representative and staff
- We saw the system in place for the submission and response to patient feedback was suitable.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Person Centred

Health Promotion
We saw information on display for patients relating to sepsis, smoking cessation and general oral health promotion. We noted charges for services were clearly displayed for patients and included within the patient information leaflet. We saw the names, General Dental Council (GDC) numbers and emergency contacts details on display. While documents were not routinely available in other languages or formats, the practice would provide those to patients upon request.

Dignified and Respectful Care
We observed staff treating patients with kindness, dignity and respect. During our inspection, we observed a deaf patient being treated with dignity, respect and understanding. We found the reception area was separate from patient waiting areas to allow for private and confidential discussions to take place in person and over the telephone. We were told that the office of the practice manager would also be made available for any particularly sensitive discussions. All surgery rooms were above the ground floor and fitted with solid doors so patients could not be overlooked while being treated.

Timely

Timely Care
We found a suitable appointments process in operation at the practice and heard from staff that delays were managed by the reception team, with the support of clinicians. Staff told us delays were infrequent and that patients were informed in a timely manner should they arise, including phone calls to patients prior to their arrival where necessary.

We were told that patients in need of an emergency appointment would be seen within 24 hours. We were also told that the practice operated a separate ‘sit and wait’ process for patients who wished to wait for a slot to become available, for example through a cancellation. We saw that appointments for those in full-time education or employment were prioritised for early morning and evening slots.

We heard from staff that NHS patients were waiting longer to see dentists due to an increase in demand and that patients could be waiting one month before an appointment could become available.

Equitable

Communication and Language
We saw clear and informative literature displayed around the practice, we noted these were available in Welsh but mostly provided in English only. Staff told us they had contacted their local health board for help with implementing the 'Active Offer'. We saw the 'Iaith Gwaith' badge being worn by some staff, and we heard Welsh being spoken by both patients and staff during our inspection. We observed a bilingual service offered, but we found this wasn't explicitly clear to patients.

The registered manager should put arrangements in place to provide a robust 'Active Offer' to patients.

We were told that any patient wishing to communicate in another language could access an over the telephone translation service.

Rights and Equality
We found detailed policies and procedures to promote the rights and equality of patients and staff at the practice. We saw the use of a patient acceptance policy and sections of the recruitment policy designed around equality and diversity.

We noted a zero-tolerance poster at reception that outlined the practice stance on abuse or harassment of their staff. Staff told us that reasonable adjustments were made for employees, including a recent example where an employee was placed on different duties due to a health condition.

We saw that transgender patients were given a choice over their preferred gender on practice systems.

Delivery of Safe and Effective Care

Safe

Risk Management
We found the practice was clean and tidy. We saw the reception area was approached by ramped access on the ground floor with stairs and a lift leading to five modern surgeries set out over the two upper floors of the three-storey practice. Patient waiting areas were dispersed throughout the building and near to the surgeries.

We saw lighting at a suitable level and communication systems working effectively. Staff changing facilities were appropriate and had lockable spaces for personal items, while we found all toilet facilities to be clean with the correct equipment present.

The decontamination room was laid out appropriately to enable the effective cleaning and sterilisation of clinical equipment. We saw separate doors for entry and exit, though we noted the exit door was propped open when it should be kept shut. We noted the temperature in the decontamination room was hot and staff explained it was routinely hot for them working in this area, which was why the door was left open.

The registered manager should ensure the environment is at a suitable temperature for staff to work in, while not keeping decontamination room doors open.

We reviewed suitable and detailed health and safety risk assessments that were reviewed annually and having last been undertaken in July 2023. The practice manager also maintained a risk assessment checklist to ensure compliance. We saw an acceptable building maintenance and continuity plan which was in date and recently updated, alongside a suitable health and safety policy. We also saw the practice employer's liability policy and health and safety executive poster on display.

We found the practice took appropriate fire safety precautions in line with national guidelines, undertaking routine assessments of the risk of fire while also having recently being assessed by a contractor in October 2023. The records we reviewed also showed:

- Fixed wire testing last took place in May 2023

- Staff conducted fire equipment checks, alarm testing and emergency lighting checks weekly
- Emergency lighting and fire extinguishers were tested every six months by a contractor with annual servicing
- Fire drills took place every six months.

We saw all staff were trained in fire safety and that fire fighting equipment was present throughout the practice with maintenance labels on all indicating compliance. Fire exits were signposted correctly and no smoking signs were displayed prominently throughout the practice.

We noted patient safety incidents were recorded in an appropriate system and there were procedures in place to report these to the relevant authorities. While there were none to review, we were assured by the process in place and staff told us any safety incident would be discussed in team meetings.

Infection, Prevention, Control (IPC) and Decontamination
We found a suitable IPC policy and satisfactory procedures in place to help ensure standards of infection control. We saw daily surgery checklists for each surgery, reviewed records of daily environmental cleaning logs and daily decontamination logs. During our inspection, we saw staff following good IPC techniques, including the routine changing of Personal Protective Equipment (PPE) and effective hand hygiene processes.

We saw sink splashbacks in the first-floor toilet were coming away from the wall, which was also the case for the splashback of the 'clean sink' in the decontamination room. We were not assured the condition of this area could promote effective cleaning. In one surgery, we saw a tear in the material of the treatment chair. In the patient waiting area on the top floor, we saw four chairs upholstered in cloth. Two of these chairs were visibly dirty, while elsewhere in the same room we saw a chair with torn material. We were not assured that these chairs could be cleaned effectively owing to their condition or their manufactured material.

The registered manager must ensure the building is maintained to enable safe cleaning and decontamination.

We saw dental equipment that was in working order and single use items were used where appropriate. We saw items, including disposable scalpels and self-curing dental material, in the decontamination room which were out of date, with staff informing us these were not routinely audited for expiry dates.

The registered manager must ensure all clinical equipment is in date and an expiry date monitoring process developed.

We saw a robust process in place for the cleaning and decontamination of reusable equipment in line with the Welsh Health Technical Memorandum 01-05. The practice undertook daily maintenance programmes, start and end of day checks on equipment and we saw a safe disinfection process for impressions. We saw weekly reviews undertaken on autoclave cycle records and saw that autoclave maintenance servicing was routine.

In the decontamination room we saw that dirty brushes and cleaning mops were being stored in the 'dirty' area of the room behind a door and that mops were being stored in their buckets.

The registered manager must ensure cleaning equipment is stored away from the decontamination process and mops correctly left to dry.

In two of the surgeries, we found drawers containing reusable clinical equipment for oral use that had been cleaned but stored uncovered. Within the same clinical drawer, we found paperwork and other non-clinical personal items.

The registered manager must ensure all clinical equipment is kept sterile and stored appropriately.

We heard from staff they felt confident with the level of training they had received and were able to name their IPC lead. We reviewed staff records that evidenced all staff were trained to an appropriate level in IPC and we saw that safer sharps devices were used to prevent injury. The use of safer sharps devices was outlined in an up to date needlestick injury protocol.

We saw evidence that all practice waste was handled appropriately by staff and through a suitable waste disposal contract. The process for the Control of Substances Hazardous to Health (COSHH) was suitably managed, risk assessed, and we found the practice COSHH folder to be suitable.

Medicines Management

We saw an appropriate medicines management policy in place that detailed the use and dispensation of medicines at the practice. We found that anaesthetics were used by the practice but that the amount used was not routinely being recorded.

The registered manager must ensure medicine doses are accurately recorded.

We found that antibiotic medicines were stored in an unused and unlocked surgery within an unlocked cupboard. Due to the potential impact on patient safety, these concerns were resolved during the inspection and the actions taken can be seen in Annex A.

We found the arrangements in place to ensure medical emergencies were safely and effectively managed were robust. We found all emergency equipment and emergency medicines to be in order and checked weekly through the use of a checklist.

We saw prescription pads which were securely stored and we noted in staff records an appropriate number of trained first aiders and all staff currently trained in cardiopulmonary resuscitation (CPR).

Safeguarding of Children and Adults
We found a suitable safeguarding policy in place, which included practice protocols outlining a named contact and contact details for the local safeguarding team. Although, we noted that the safeguarding policy did not link to the All-Wales Safeguarding Procedures.

The registered manager should consider reviewing their safeguarding policy to fully align with the All-Wales Safeguarding Procedures.

In our discussions with staff, they explained the process they would follow in the event of a concern, they outlined how they would feel confident raising a concern and named the safeguarding lead. We saw in staff records that all staff were trained to an appropriate level in adult and child protection.

Management of Medical Devices and Equipment
We found a comprehensive process in place to ensure clinical equipment was safe and maintained appropriately. The clinical equipment we saw was safe, in working order and suitable for the purpose intended.

The policies, procedures and protocols in place for radiation all supported the safe and effective care of patients. We found safe arrangements in place for the environment, maintenance and testing of X-ray equipment, this included the details of controlled areas, a programme of review of local rules and risk assessments as well as the arrangements for investigating and reporting incidents. We reviewed a suitable radiation protection folder that contained all of the required information for the radiological equipment.

On review of the staff records, we saw that all were appropriately trained in the safe use of X-ray equipment, which included a session as part of the induction process.

Effective

Effective Care

We heard from staff that they were clear on their responsibilities for the safe assessment, diagnosis and treatment of patients. We found that treatment was delivered in line with professional, regulatory and statutory guidance. We saw a robust process in place to record and escalate patient safety incidents. Whilst there were no patient safety incidents for us to review, we were assured by the processes that were in place.

We saw the use of clinical checklists such as the Local Safety Standards for Invasive Procedures (LocSSIPs).

Patient Records

We found a suitable system in place for record keeping and records management, which stored records securely and in line with the General Data Protection Regulations. We also found an appropriate consent policy in place for patients.

We reviewed a total of 10 patient records, and identified the following areas that required strengthening:

- X-ray justifications, the clinical findings and the quality grading of each radiograph were only recorded in two of the applicable patient notes we reviewed
- Oral hygiene was recorded in three of the notes reviewed
- Informed consent was not recorded in four of the records reviewed, while we saw no evidence of the risks and benefits of X-rays being explained
- Treatment plans were only provided in one of the applicable records we reviewed
- The recording of cancer screening was present in only one patient record
- Recalls were not recorded in six of the records reviewed
- Patient choice of language was not recorded in any record.

Of the patient records we reviewed, we saw that more detail was needed regarding:

- Impression materials and the type of cement used to fit a crown
- Extra oral, intra oral examination, soft tissue examination, the risk assessment of cavities and tooth wear.

The registered manager must ensure accurate, comprehensive and complete patient records are kept at all times in line with GDC requirements and Faculty of General Dental Practice UK guidelines.

Efficient

Efficient

We found patients were given timely access to care through a robust triage process to prioritise those with the most urgent need, including the use of a cancellations list to use clinicians time effectively. We saw services being delivered in line with the clinical needs of patients in a suitably sized and staffed premises. We noted an appropriate means for the referral of patients to other services and saw these referrals were monitored by practice staff.

Quality of Management and Leadership

Leadership

Governance and Leadership
We found a defined management structure in place, which included the support of an area manager for multiple Brynteg Dental practices. Staff told us they knew who to speak with if they needed any management advice and leaders told us they felt supported by the Brynteg Dental group in undertaking their roles.

Staff told us they took part in the Maturity Matrix Dentistry for team development and we saw meeting minutes showing that team meetings were held regularly for staff to discuss patient feedback, complaints and staff wellbeing.

Staff told us they recently undertook an all-staff away day which focused on staff wellbeing. Staff told us these were regularly undertaken to support team development and provide the whole team a day away from the workplace together.

We saw the practice operated a rota system for their staff to ensure there was a sufficient number of suitably qualified and trained staff working at any one time. The practice manager used a messaging group to seek cover during shortages due to absence and had access to the staff of other Brynteg Dental group practices, where needed. We saw that the use of agency staff was infrequent, with the last agency staff member used over 12 months ago.

Workforce

Skilled and Enabled Workforce
We saw comprehensive support of staff training and development at the practice from the six out of eighteen staff records we reviewed. We noted a suitable staff development and training policy, observing in all of the records we reviewed that staff had completed their mandatory training courses. We also saw staff that had exceeded the level of training required and the staff we spoke to explained they felt supported to undertake training. We found that staff appraisals had not taken place since 2021.

The registered manager must ensure staff appraisals occur annually as a minimum.

On review of the six staff records we observed the following regarding staff professional obligations:

- GDC registrations were overseen by practice management using an online system
- Disclosure and Barring Service Enhanced checks were routine
- Indemnity insurance was in place for all clinical staff
- Hepatitis B checks were undertaken as part of the recruitment process
- Job descriptions and contracts of employment were in place.

We saw that employment history checks and references checks were not routine for employees. In all eighteen staff records, we saw that only three had these documents kept on file. Staff told us there had been a recent change in ownership and staff employed previously did not have that information stored on file. We noted that all new starter records had appropriate checks in place and supported by a comprehensive recruitment policy and procedure.

The registered manager must provide assurance to HIW of the risk mitigation in place relating to missing pre-employment check records.

Culture

People Engagement, Feedback and Learning
We found an appropriate system in place for the submission and response to patient feedback through the use of forms at reception. Where received and acted upon, a poster is placed at reception explaining how the practice has responded. We saw that carers were able to complete feedback on behalf of patients and verbal feedback was also captured. Staff told us that feedback was collated and discussed at practice meetings.

We saw complaints were managed in line with Putting Things Right and we saw posters on display communicating this to patients. We observed a clear protocol in place to manage and respond to complaints through the use of a complaints management system. We reviewed a sample of complaints and did see a common theme around the access to NHS care and how telephone lines at the practice could get busy.

We reviewed a comprehensive Duty of Candour policy which clearly outlined the responsibilities for staff and those staff we spoke to confirmed their understanding of the policy. We also heard that staff were encouraged by management to raise a Duty of Candour concern and we saw that training had been organised for all staff. The practice had not reported any Duty of Candour incidents for us to review.

Learning, Improvement and Research

Quality Improvement Activities

On review of the practice records regarding quality improvement, we observed record cards audits were routine and last took place in October 2023. Health and safety audits took place regularly, having last been completed in June 2023 while fire safety, hand hygiene and decontamination and IPC were also frequent and all last took place in July 2023.

We saw that antibiotic prescribing audits last took place in January 2023 and we saw evidence of peer review audits taking place across the Brynteg Dental group. We did not see evidence of smoking cessation audits taking place.

The registered manager must undertake smoking cessation audits.

While we saw evidence that audits were taking place, we identified a number of issues outlined elsewhere in this report relating to IPC and patient records which should have been picked up during an audit.

The registered manager must improve the effectiveness of their audit procedures, considering the support available through Health Education and Improvement Wales (HEIW).

Whole Systems Approach

Partnership Working and Development

In our discussions with staff, we were told working relationships with the wider healthcare system were satisfactory, explaining that working with local GP's and the local pharmacy enabled them to provide better care to patients. We saw their processes for referrals was efficient and managed appropriately by the practice staff, including any follow up actions.

We saw working relationships between the local team and the corporate staff from Brynteg Dental group were good and this was confirmed by what staff told us.

4. Next steps

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 immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: 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.

The improvement plans 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 inspection.

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.

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
We found that antibiotic medicines were stored in an unused and unlocked surgery within an unlocked cupboard.	Risk to patients gaining unauthorised access to controlled medicines.	Discussed with managers on the day of inspection.	Medicines were secured.

Appendix B - Immediate improvement plan

Service: Brynteg Carmarthen Dental Practice

Date of inspection: 30 October 2023

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
No further immediate concerns were identified on 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:

Appendix C - Improvement plan

Service: Brynteg Carmarthen Dental Practice

Date of inspection: 30 October 2023

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.

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
We saw clear and informative information displayed around the practice, we noted this literature was available in Welsh but mostly provided in English only. We observed a bilingual service offered to patients, but we found this wasn't proactively offered.	The registered manager should put arrangements in place to provide a robust 'Active Offer' to patients.	Private Dentistry (Wales) Regulations 2017 Section 13 (1) (a)	We have previously been in contact with The local health regarding this and they are going to provide us with the relevant links for the information to be provided in welsh .I have chased this up again with Joanna cloke. I've also placed signs around the practice informing patients that a bilingual service is	Cathy Jones - Hiw registered manager and Zoe Paynter Practice Manager	1 month

			available within the practice		
We noted the exit door of he decontamination room was propped open when it should be kept shut. We noted the temperature in the decontamination room was hot and staff explained it was routinely hot for them working in this area, which was why the door was left open.	The registered manager should ensure the environment is at a suitable temperature for staff to work in, while not keeping decontamination room doors open.	Section 22 (2) (a)	Discussion had immediately with the senior nurse and a meeting had with all staff members. Everyone is aware of the importance of keeping the exit door closed Also report has been sent to Todays dental and asked them to look at what improvements can be made to the room to improve the temperature and ventilation in the room so its not as warm for staff members	Zoe Paynter Practice Manager Cathy Jones HIW registered manager	Done immediately 3 Months
We saw sink splashbacks in the first-floor toilet were coming away from	The registered manager must ensure the building is maintained to enable safe	Section 22 (2)	We have recently been taken over by Todays Dental and this is	Cathy Jones	3 months

the wall, which was also the case for the splashback of the 'clean sink' in the decontamination room. This left areas behind the splashbacks to become contaminated. In one surgery, we saw a tear in the material of the treatment chair. In the patient waiting area on the top floor, we saw four chairs upholstered in cloth. Two of these chairs were visibly dirty, while elsewhere in the same room we saw a chair with torn material. We were not assured that these chairs could be cleaned effectively owing to their condition or their manufactured material.	cleaning and decontamination.		something which is on the list to be improved , we have had builders come out to look around and list the improvements . New waiting area and seating arrangements were on the list and general maintenance and improvement eg toilets splashback areas were also noted at the time . Report has been sent to Todays and these improvements have been chased up and asked for a possible date for then this work can be started	HIW registered manager	

We saw items, including disposable scalpels and self-curing dental material, in the decontamination room which were out of date, with staff informing us these were not routinely audited for expiry dates.	The registered manager must ensure all clinical equipment is in date and an expiry date monitoring process developed.	Section 13 (2) (a)	Discussion had immediately with senior nurse and decon lead. Stressed the importance that these need to be checked on a regular basis . A log sheet was created for all staff members to check monthly for expired materials . staff members made aware of this . Logsheets are audited and montitored on a regular basis by our senior nurse	Zoe Paynter Practice Manager	Done and completed immediately
In the decontamination room we saw that dirty brushes and cleaning mops were being stored in the ‘dirty’ area of the room behind a door and that mops were being stored in their buckets.	The registered manager must ensure cleaning equipment is stored away from the decontamination process and mops correctly left to dry.	Section 22 (2) (a)	Discussion had with our senior nurse and decon lead . These items were removed immediately and placed in our store room. I also arranged for a hook to be placed on the wall so the	Zoe Paynter Practice Manager	Done and completed Immediately

			mops could be hung up to dry correctly		
In two of the surgeries, we found drawers containing reusable clinical equipment for oral use that had been cleaned but stored uncovered. Within the same clinical drawer, we found paperwork and other non-clinical personal items.	The registered manager must ensure all clinical equipment is kept sterile and stored appropriately.	Section 13 (3)	Meeting had with all clinical staff, informed them of the findings. Drawers separated Into a clinical and non clinical draw ,stressed the importance of this . Clinical items which had been cleaned and stored uncovered were immediately removed from this area, resterilised, and bagged and were effectively stored in the correct draw .	Zoe Paynter Practice Manager	Completed and done immediately
We found that anaesthetics were used by the practice but that the amount used was not routinely being recorded.	The registered manager must ensure medicine doses are accurately recorded.	Section 13 (4)	Meeting had with all dentists and therapists in the practice, Staff informed of findings .stressed the importance of this and explained it needs to	Zoe Paynter Practice Manager	Completed and done immediately

			be recorded in all notes .Template notes have been adjusted to encourage recording of this .		
We noted that the safeguarding policy did not link to the All-Wales Safeguarding Procedures.	The registered manager should consider reviewing their safeguarding policy to fully align with the All-Wales Safeguarding Procedures.	Section 14 (1) (a)	Policy reviewed immediately by myself and rectified so it was fully in line with the all-wales safeguarding procedure	Zoe Paynter Practice manager	Done and completed immediately
X-ray justifications, the clinical findings and the quality grading of each radiograph were only recorded in two of the applicable patient notes we reviewed Oral hygiene was recorded in three of the notes reviewed Informed consent was not recorded in four of the records reviewed, while	The registered manager must ensure accurate, comprehensive and complete patient records are kept at all times in line with GDC requirements and Faculty of General Dental Practice UK guidelines.	Section 20 (1)	A lengthy discussion was had with principle dentist,associates and therapists regarding this matter . They was all informed of these findings . explained and stressed that accurate patient records are a must and essential. As per practice policy, all of the findings are essential for all	Zoe Paynter Practice Manager and Cathy Jones HIW registered manager	Done and completed immediately

we saw no evidence of the risks and benefits of X-rays being explained Treatment plans were only provided in one of the applicable records we reviewed The recording of cancer screening was present in only one patient record Recalls were not recorded in six of the records reviewed Patient choice of language was not recorded in any record. Of the patient records we reviewed, we saw that more detail was needed in patient records regarding:			patients and should be recorded in the patient notes without fail . Template notes have been adjusted to encourage recording of all findings. Regular monitoring of clinicians notes undertaken to ensure this doesn't happen again. In regards to Patient choice of language and how we can record this on the file, I will have a discussion with Dentally to see if there is a drop down box which can be added to the patient details and file so this is made aware to all staff members.	Zoe Paynter Practice Manager	1 month

Impression materials and the type of cement used to fit a crown Extra oral, intra oral examination, soft tissue examination, the risk assessment of cavities and tooth wear.					
We found that staff appraisals had not taken place since 2021.	The registered manager must ensure staff appraisals occur annually as a minimum.	Section 17 (4)	With the recent take over in owners and companies, we ere waiting for further guidance on whether they wanted different protocols or methods put in place, weve since had confirmation that these can stay the same so time blocked off for uptodate appraisals to be done in the upcoming weeks by myself .	Zoe Paynter Practice Manager	1 month

We saw that employment history checks and references checks were not routine for employees. In all of the eighteen staff members records, we saw that only three had these documents kept on file. Staff told us there had been a recent change in ownership and staff employed previously did not have that information stored on file.	The registered manager must provide assurance to HIW of the risk mitigation in place relating to missing pre-employment check records.	Section 18	Discussion had between myself Zoe Paynter and cathy jones regarding this matter and how we can rectify this with some of our longstanding staff members . we both agreed that we would construct a policy for this and for longstanding staff members some being us from leaving school 10 + years ago then we are looking at getting character references for these staff members from a professional member of the public or family member to cover this missing information	Zoe Paynter Practice Manager Cathy Jones HIW registered manager	2 months

We did not see evidence of smoking cessation audits taking place.	The registered manager must undertake smoking cessation audits.	Section 16 (1) (a)	Discussion had with principal dentist and senior nurse, we have since registered to complete a smoking cessation audit with the post graduate department and this is currently being done , we have also registered for the SOSET audit to be completed and that is also currently being done here at the practice	Zoe Paynter Practice Manager	1 month
While we saw evidence that audits were taking place, we identified a number of issues outlined elsewhere in this report relating to IPC and patient records which should have been picked up during an audit.	The registered manager must improve the effectiveness of their audit procedures, considering the support available through Health Education and Improvement Wales (HEIW).	Section 16 (1) (a)	Discussion had with Cathy Jones and myself Zoe Paynter about ways which this can be improved . We both agreed that regular monitoring and reviews of patient notes will be done and on the next audit for patient notes and records we both	Zoe Paynter Practice Manager	3 months

			suggested increasing the number of notes which will be audited and also both agreed that using the support which is provided by the HEIW when it comes to audits to make sure the effectiveness of these audits are improved .		

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): Zoe Paynter

Job role: Practice Manager

Date: 18/01/2024