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West Face Orthodontics

Inspection Report

West Face Orthodontics
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Overall summary

We carried out an announced comprehensive inspection on 17 March 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulation.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Background

CQC inspected the practice on 22 May 2012 and asked the provider to make improvements in the training provided to staff about safeguarding vulnerable adults and children. We checked these areas as part of this comprehensive inspection and found this had been resolved.

West Face Orthodontics, is a private dental practice which also treats NHS patients. The practice receives self referrals and referrals from dental professionals such as a patient's own dentist, for second opinion or treatment planning. The practice specialises in orthodontics treating patients with bite problems and improvement of teeth aesthetic and appearance. The orthodontist works with other dental specialists to move teeth to the correct position to accommodate prosthetics such as implants and bridges to replace missing or absent teeth. The practice is situated in a converted domestic dwelling situated in the centre of St Austell, Cornwall. The practice has two dental treatment rooms, an x-ray room and a separate decontamination room used for cleaning, sterilising and packing dental instruments. The practice operates over two floors. The provider is the only orthodontist working at the practice and is supported by two dental nurses, and a receptionist. The practice's opening hours are 8.30 am to 1 pm and 2pm to 4 pm Monday to Thursday.

Summary of findings

The principal dentist is registered with the Care Quality Commission (CQC) as an individual.

A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We collected 49 completed cards and obtained the views of six patients on the day of our visit. These provided a positive view of the services the practice provides. All of the patients commented that the quality of care was good.

We carried out an announced comprehensive inspection on 17 March 2016 as part of our planned inspection of all dental practices. Our inspection was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

- The practice ethos was to provide high quality patient centred care at all times.
- Staff had been trained to handle emergencies and appropriate medicines were readily available in accordance with current guidelines.
- The practice was clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a dedicated safeguarding lead professional and effective safeguarding process in place for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- The orthodontist and dental nurses provided specialised orthodontic services in accordance with current professional guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment, urgent and emergency care when required.
- The practice had an orthodontist who provided a range of more specialised orthodontic services, which is a special part of dentistry that deals with straightening teeth and influencing bone growth. There were enough supporting staff to deliver the services on offer.
- Staff had received training appropriate to their roles and were supported in their continuing professional development.
- Staff we spoke with felt well supported by the practice owner who was committed to providing a quality service to their patients.
- Information from 49 completed CQC comment cards and six patients who were asked for their views of the service on the day of our visit gave us a positive picture of a friendly, caring and professional service.

There were areas where the provider could make improvements and should:

- Review availability of equipment such as an automated external defibrillator (AED), to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the security of prescription pads in the practice and ensure there are systems in place to monitor and track their use.
- Review its responsibilities as regards to the Control of Substance Hazardous to Health (COSHH) Regulations 2002 and, ensure data sheets are obtained so that staff understand how to minimise risks associated with the use of and handling of these substances.
- Review and update the current legionella risk assessment and implement the required actions including the monitoring and recording of water temperatures, giving due regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.

A month after the inspection the provider sent us evidence demonstrating that all of the above issues had been addressed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

The practice had reliable arrangements in place for essential safety such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. However, there were minor gaps in systems managing the Control of Substances Hazardous to Health (COSHH), reviewing and reducing the risk of legionella infection and the security of prescription pads in the practice. A month after the inspection, the provider sent evidence demonstrating that these had been addressed. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

The orthodontic care provided was evidence based and focused on the needs of the patients. The practice used current national professional guidance to guide their practice. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council and were meeting the requirements of their professional registration.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

We collected 49 completed cards. These provided a positive view of the service; we also sought the views of six patients on the day of our visit which also reflected these findings. All of the patients commented the quality of care was good. All six patients and their relatives accompanying them we asked on the day of our visit told us they would recommend West Face Orthodontics, to someone needing specialist treatment.

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations.

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access specialised treatment and urgent after care when required. The practice provided patients with written information about how to prevent dental problems and maintain the dental appliance, such as a fixed brace, during treatment. Dental treatment rooms were situated on the first floor. The practice did not have lift access to these rooms. However, the impact of this was reduced for patients because referring dental practices instead referred patients with mobility problems to a hospital based service for specialist treatment.

Are services well-led?

We found that this practice was providing well led care in accordance with the relevant regulations.

The practice had robust clinical governance and risk management structures in place. The registered provider was seen as very approachable by staff who felt well supported in their roles and could raise any issues or concerns with them any time. The culture within the practice was seen as open and transparent. Staff told us they enjoyed working at the practice and were proud of the dental transformations achieved for patients in terms of appearance and bite.

West Face Orthodontics

Detailed findings

Background to this inspection

We inspected West Face Orthodontics on 17 March 2016. The inspection was led by a CQC inspector who was accompanied by a specialist advisor.

Before the inspection, we reviewed all the information we held. This included the last inspection report dated May 2012, at which a legal requirement was made. The practice had provided an action plan demonstrating that staff had since received training about safeguarding procedures. Pre-inspection information was sent by the principal orthodontist and included details to confirm that no written complaints had been received, and provided staff information and the current statement of purpose outlining the aims of the service.

We informed NHS England area team that we were inspecting the practice. They confirmed that this practice was not an outlier (needing closer monitoring) and they had received no concerning information about it.

The methods that we used at this inspection included: talking to six people using the service, their relatives / friends, interviewing staff, observations, review of documents and 49 comment cards from patients.

The practice provides both private and NHS orthodontic services.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had developed significant event forms for staff to complete when something went wrong. The practice had not incurred any recent significant events. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) via post or email. The alerts were kept for reference and the practice had acted upon any of the alerts that were specific for dental practice. Relevant alerts were discussed during staff meetings to facilitate shared learning.

Reliable safety systems and processes (including safeguarding)

We spoke with the lead nurse for infection control about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU Directive with respect to safe sharp guidelines, thus protecting staff against blood borne viruses. The practice used a system whereby needles were not manually re-sheathed, but rarely used needles as local anaesthetics were not used at the practice and only had these in the emergency drug case. Staff were responsible for disposing of sharp equipment used during treatment into the appropriate sharps bin. Staff we spoke with were able to explain the practice protocol in detail should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps. The practice reported that there had been no sharps injuries during 2015.

We asked how the practice treated the use of instruments that were used during orthodontic treatment. They explained that the majority of these instruments were specialised equipment and sterilised. Some single use items were used such as plastic covers for lights, suction pipes and mouth spray tubes and we saw these being replaced with new equipment after every patient.

The orthodontist we spoke with explained that the orthodontic treatments they were delivering, meant that a rubber dam was rarely used as this was not appropriate. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. Staff had received first aid training. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen were all in date and stored in a central location known to all staff. The expiry dates of medicines and equipment were monitored using a monthly check sheet that enabled staff to replace out of date medicines and equipment promptly.

However, the practice did not have an automated external defibrillator (AED), a portable electronic device that analyses life-threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. We discussed this with the principal orthodontist who told us that the orthodontic treatments carried a low risk and therefore felt that an AED was not warranted at the practice. Immediately following the inspection, the provider verified that they had reviewed the situation and would be purchasing an AED which would be in place once they re-opened after the Easter holiday break.

Staff recruitment

All six patients we spoke with told us they had confidence and trust in the dentist. The dentist and dental nurses who worked at the practice had current registrations with the General Dental Council. The practice had a recruitment policy which detailed the checks required to be undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications and employment checks including references. Staff working at the practice were long serving employees and no new staff had been recruited since the practice registered with CQC. Five out of the six staff employed at the practice had staff recruitment files demonstrating that they had completed on-going training and clinical updates. We fed back to the Principal orthodontist that cleaning staff employed by the practice should also have a staff recruitment file with evidence of on-going training updates and other employment information. A month after the inspection, the principal orthodontist verified that cleaning staff now had a personnel file.

Are services safe?

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice carried out a number of risk assessments including a Control of Substances Hazardous to Health (COSHH) file. However, the practice did not routinely hold COSHH data sheets on this file. The principal orthodontist said that they would obtain these for all substances used in the practice. Other assessments had been completed and included fire safety, health and safety and water quality risk assessments. Records showed that electrical equipment was last checked by an external contractor in February 2016.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had a decontamination room for the processing of contaminated instruments. It was noted that the two dental treatment rooms, waiting area, reception and toilets were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms and toilets. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The lead nurse described the end to end process of infection control procedures and we saw these followed current guidelines. For example, we saw a robust system of instrument tracking in place which consisted of paper records. This included an audit trail showing when the system helped to prevent loss of instruments to the service as well as being able to trace instruments in the event of a patient suffering from a healthcare acquired infection. The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. She demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines. The orthodontist chose to work concurrently with one of two nurses on duty. This meant whilst one treatment room was being cleaned and set up, the other one was being used to treat the next patient. We observed that this system worked efficiently and ensured that patients were seen on time.

The drawers of one of the treatment rooms were inspected in the presence of the dental nurse. These were well stocked, clean, well ordered and free from clutter. All of the instruments were pouched and the majority were single use only and opened at the point of treatment in front of the patient. Each treatment room had the appropriate personal protective equipment available for staff and patient use.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) the dental nurse described the method they used which was in line with current HTM 01 05 guidelines, which set out how infection control risks should be managed in dentistry. A Legionella risk assessment had been carried out at the practice, these measures ensured that patients' and staff were protected from the risk of infection due to Legionella. However, this had not been reviewed in the last 12 months.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We saw that sharps containers, clinical waste bags and general waste were properly maintained and disposed of in accordance with current guidelines. The practice used an external contractor to remove dental waste from the practice and was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. The systems in place provided assurance that patients were protected from the risk of infection from contaminated dental waste.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the two autoclaves had been serviced and calibrated within the last 12 months. The practice X-ray machine had been serviced annually and had been calibrated within the last 12 months. This was in accordance with the national ionising regulations. Electrical testing and portable appliance testing (PAT) had also been carried out.

Patient orthodontic treatment records demonstrated that batch numbers and expiry dates for local anaesthetics were recorded. These medicines were stored securely for the protection of patients. All of the clinical and reception staff had received update training in medicines management July 2015.

Are services safe?

The practice did not dispense any medicines to patients but provided information about simple pain relief that could be used if they needed it. The orthodontist told us that prescription scripts for antibiotic medicines were rarely issued due to type of treatments provided at the practice. A prescription pad was securely stored. However, there were some gaps in the systems in place to monitor its use. Staff verified that they recorded any prescriptions issued to patients in the electronic file for that person. However, there was no central tracking system with serial numbers to identify what scripts were held at the practice or issued to patients. This meant that in the event of a theft, the practice would not be able to provide an audit trail when reporting this to authorities so that potential misuse of these could be prevented. In April 2016, the principal orthodontist verified that a prescription logging system was now in place.

None of the treatment for patients was performed under conscious sedation.

Radiography (X-rays)

The location maintained radiography equipment in line with Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). We looked a file that contained all the necessary documentation pertaining to the maintenance of the X-ray equipment.

Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of 3 years. A sample of orthodontic treatment records where X-rays had been taken showed that when dental X-rays were taken they were justified, reported on and quality assured. The X-ray audits for the practice were managed by the lead dental nurse. A copy of the most recent radiological audits for the orthodontist was available for inspection, this demonstrated that a very high percentage of radiographs taken were of a high standard of quality. These findings showed that the location was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The principal orthodontist carried out consultations, assessments and treatment in line with recognised general professional guidelines. They described to us how they carried out their assessment of patients for the specialist care they provided. The practice received referrals from other dental practices and provided both NHS and private treatment. At the outset of a course of treatment, a comprehensive assessment was undertaken with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of oral cancer. The dentist explained that patients would receive any ongoing support or treatment for this at their regular dentist who provided general dentistry care.

Six patients told us that following the initial assessment, the dentist had discussed treatment options with them at length and explained these in detail. A plan was printed out and patients given time to consider this before agreeing to the proposed treatment plan. We saw that this was reviewed with the patient at their appointment, amended according to their needs and future appointments booked. For example, we saw a consultation with a young person who was accompanied by a parent for whom the orthodontist recommended removal of some teeth. We were told this would be carried out by the patient's general dentist. If the patient and their parent chose this option, the orthodontist said they would write to the patient's general dentist with his recommendations.

Health promotion & prevention

The practice was very preventative focused, adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. The principal orthodontist explained that they worked in collaboration with the referring dental practices, which provided ongoing general dentistry care for patients attending for specialist treatment.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. We observed that the dentist discussed the patient's oral hygiene routine and gave feedback and support about caring for the fixed brace during the treatment period. This included dietary advice and general dental hygiene procedures such as tooth brushing techniques or recommended tooth care products.

This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. The waiting room and reception area at the practice contained leaflets that explained the services offered at the practice. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

We observed a friendly atmosphere at the practice. All six patients we asked told us they felt there were enough staff working at the practice. Staff we spoke with told us the staffing levels were suitable for the size of the service. All the staff we spoke with told us they felt supported by the orthodontist who was also the owner of the practice. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

The practice was run by a principal orthodontist who had advanced qualifications enabling them to provide specialist orthodontic treatments. They were supported by two highly qualified and experienced dental nurses, as well as a receptionist. This meant that the practice was very well resourced as the principal dentist had opted to have a 2:1 dental nurse to patient ratio. This meant that whilst a patient was being treated, the second dental nurse prepared the other treatment room in readiness for the next patient. Patients told us the team was efficient and they had confidence in them. They said their appointments always ran on time, which they told us they appreciated.

Working with other services

The practice was a referral practice and a self-contained service. However, there were occasions when patients needed to be referred to other specialists outside of the practice. The practice used referral criteria and referral forms developed by providers in the locality. This ensured that patients were seen by the right person at the right time. When the patient had completed their orthodontic treatment, they were discharged back to their general dental practitioner for ongoing dental health monitoring. A copy of the referral letter was always available to the patient if they wanted this for their records. The orthodontist reported that there were no patient complaints relating to referrals to specialised services.

Are services effective?

(for example, treatment is effective)

NHS England oversaw the contract delivered by the practice for NHS orthodontic care and treatment. They told us that no concerns had been received from patients or other stakeholders about the quality of care and treatment or communications from and with the practice.

Consent to care and treatment

We asked the principal orthodontist how they implemented the principles of informed consent. They demonstrated they had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. These findings were then given to the patient after the consultation. The orthodontist stressed the importance of communication skills when explaining care and treatment to patients. We saw they did this in a way that ensured patients understood their treatment options.

All six of the patients we met at the inspection were young people, the majority accompanied by a parent.
The orthodontist explained that the majority of referrals received were for children and young people. Adult patients tended to attend the practice for private treatment and were able to give informed consent. The orthodontist and dental nurses demonstrated that they had a clear understanding about issues of consenting unaccompanied young people. Staff files demonstrated that all of the clinical staff had had training about Gillick competency. Gillick competence is outlined in national guidelines in respect of the care and treatment of children under 16. These principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Whilst parental consent was obtained for majority of patients or from themselves the orthodontist was also able to describe how they would obtain consent from a patient who suffered with any mental impairment. Treating a patient with mental impairment could mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, the orthodontist told us that the treatment would be postponed and they would liaise with the dental practice the patient normally attended. The orthodontist also spoke about involvement of a patient's nearest relative/carer if appropriate to ensure that the best interests of the patient were met. This followed the guidelines of the Mental Capacity Act 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The treatment rooms in the practice were situated upstairs away from the waiting area. Patient's privacy was maintained throughout their consultation and treatment. Patients' clinical records were stored electronically. Computers were password protected and regularly backed up to secure storage.

Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission comment cards to the practice for patients to use to tell us about their experience of the practice. We collected 49 comment cards and obtained the views of six patients and their parents accompanying them on the day of our visit. These provided a positive view of the service the practice provided. Patients told us that the quality of care was very good and they recommended the service. Some of the parents told us that siblings of the children and young people being seen had also attended for treatment. They all spoke about the positive outcomes of past treatment and how in many circumstances this had improved their child's confidence and mental well-being.

On the day of our visit, we witnessed all of the patients being treated with dignity and respect through every step of their appointment.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed options and indicative costs. We saw that the orthodontist and nurses focused on patient involvement when drawing up individual care plans. Patient records showed that the information provided to patients about their treatment and the options open to them had been documented.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice waiting area displayed a variety of information including information about different types of treatment the practice offered. We were shown the information given to new patients which included, step by step stages of the treatment requested, consent for X-rays and privacy statement, complaints procedure, medical history questionnaire and information about the dentist performing the treatment.

We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments for varying complexity of treatment. The appointment booking system had provision for emergency slots at the end of each morning and afternoon surgery which meant patients could be seen in timely fashion and routine appointments kept to time. The principal orthodontist told us that often the emergency appointments were used by patients when a fixed brace needed urgent repair. The appointment system also provided flexibility for children and young people to be seen at the end of the school day or over part of the lunch time period.

Tackling inequity and promoting equality

The practice was based over the ground and first floor of a converted former domestic dwelling. The building was spacious over both floors. The principal dentist verified that all of the patients being referred to the practice had no limitations with mobility. Referring dental practices used another hospital based specialist provider for anyone needing reasonable adjustments due to limitations with mobility or communication difficulties. We were told that translation services could be made available if required.

Access to the service

West Face Orthodontics offered NHS and private specialist dental care services for adults and children between 8.30 am to 1pm and 2pm to 4pm Monday to Thursday. Appointments could be made in person, via the practice website or by telephone.

Patients told us they were able to get appointments when they needed them. We asked six patients if they were satisfied with the practices' opening hours. They all said they were very satisfied.

There were arrangements in place to ensure patients received urgent orthodontic assistance when the practice was closed. This was provided by an out-of-hours service. If patients called the practice when it was closed, an answerphone message gave the telephone number patients should ring depending on their symptoms. We saw the dental nurses explaining that the practice was closed for three weeks over Easter and what arrangements were in place should they need any support in day time hours.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. For example, a complaint would be acknowledged within three days and a full response would be provided to the patient within ten days. We were told the practice had received no complaints in the previous 12 months. Information for patients about how to make a complaint was seen in the patient information pack which was given to all new patients. Patients and their parents told us they were very satisfied with the quality of care and treatment and had had no reason to complain.

NHS England oversaw the contract delivered by the practice for NHS orthodontic care and treatment. They confirmed that they had received no concerns from patients or other stakeholders about the quality of care or communications with the practice.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for West Face Orthodontics consisted of the principal orthodontist who was responsible for the day to day running of the practice. We saw a number of policies and procedures in place to govern the practice covering a wide range of topics. For example, control of infection and health and safety. The principal orthodontist had recognised that they needed extra support to ensure that all policies and procedures were reviewed to support the safe running of the service. Documentation seen verified that the principal orthodontist had engaged an external health and safety management consultant to assist with this. Staff were aware of where policies and procedures were held and were easily accessible.

Leadership, openness and transparency

The practice had a statement of purpose that described its vision, values and objectives. Staff told us that there was an open culture within the practice which encouraged candour and honesty. There were clearly defined leadership roles. The ethos of the practice was to provide high quality dental treatment that would have a positive impact for their patients in terms of appearance and bite.

It was apparent through our discussions with all of the staff that improved patient well-being was at the heart of the practice and the dentist adopted a holistic approach with them. Staff were hard working, caring and committed to providing quality orthodontic care and treatment that made a difference to people.

The staff we spoke with described a positive culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the principal orthodontist. They felt they were listened to and responded to when they did raise a concern. Staff told us they enjoyed their work and were well supported.

Learning and improvement

The principal orthodontist was the only orthodontist working at the practice and provided enthusiastic leadership. The staff we met described him as being approachable and felt that they benefitted from having direct clinical supervision working with him every day. We saw evidence of systems to identify staff learning needs. For example, annual appraisals were used to identify additional training or clinical supervision needs and improve confidence and competence in particular clinical techniques.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had systems in place to seek and act upon feedback from patients using the service. These included inviting patients to complete a brief survey following their visit to the practice. We saw a number of different monthly patient satisfaction surveys which had been analysed over the previous year which showed that patients were very satisfied or satisfied with the service they received. At the end of four consultations, we saw the principal dentist and dental nurse ask the patient, and if accompanied, their parent, for feedback. All of the patients expressed high levels of satisfaction and praised the team for the care and treatment they had received. Comments from several parents highlighted that there was multigenerational family experience of the practice with parents and siblings also having successfully completed treatment with improved smiles and confidence.

We saw a robust complaint procedure in place, with details available for patients in the information provided to them upon registration.

Staff told us they felt included in the running of the practice and how the registered provider listened to their opinions and respected their knowledge and input at meetings. Staff told us that they had team building events, including evenings out and lunches.