Smile Arts Studio PVT Ltd

Andover Smile Centre

Inspection Report

Andover Smile Centre
31 Junction Road
Andover
Hampshire
SP10 3QU
Tel: 01264 323033
Website: www.andoversmilecentre.com

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Overall summary

The inspection took place on 15 January 2015 as part of our national programme of comprehensive inspections. This practice had not previously been inspected under the current ownership.

Andover Smile Centre provides private dental treatment to patients of all ages. The practice provides general dental services and specialist treatments such as orthodontics, implants and inhalation sedation. (This form of sedation is a mixture of anaesthetic gas and oxygen breathed through a nosepiece. This helps patients to feel relaxed and accept treatment). The practice team consists of the principal dentist, who is the registered manager, a part time dentist a visiting implantologist and two part time dental hygienists. The clinical team are supported by four dental nurses one of whom works as the practice receptionist.

The practice consists of two treatment rooms with a reception and waiting area in between. All patient areas are on the ground floor with access suitable for all patients. There is a ramp and flat access to the practice building; however the practice toilet cannot be accessed by patients who require the use of a wheelchair.

During our inspection we spoke with four patients and reviewed 22 comments cards, which patients had completed in the week before our visit. All patients commented positively about the care and treatment they had received and the friendly, efficient and professional staff. A number of patients commented on the sympathetic, understanding dentist who had helped them overcome their fears and to make them more relaxed patients.

Our key findings were:

- The practice provided a clean well equipped environment
- All staff were kind and caring in the way they dealt with patients
- There was a regular schedule of staff meetings which included staff training.
- Patients were able to make routine and emergency appointments when needed. There were clear instructions for patients regarding out of hours care.
- There was clear leadership of the practice and staff told us they felt well supported and comfortable to raise concerns or make suggestions.

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

- Ensure the Infection control policy is updated to reflect the registered name of the practice and the layout of the practice premises.
- Provide staff with refresher training in safeguarding children and vulnerable adults to meet the requirements of their own practice training policy.

Summary of findings

- Complete the risk assessment for Legionella and initiate a programme of monitoring.
- Complete a risk assessment in relation to dental hygienists working without dental nurse support.

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?

The infection prevention and control practices at the practice followed current essential quality requirements. All equipment at the practice was regularly maintained, tested and monitored for safety and effectiveness.

The practice had the recommended medicines and equipment available to deal with a medical emergency should it occur; staff were trained to deal with such emergencies.

Care and treatment of patients was planned and delivered in a way that ensured their safety and welfare. Patients' medical histories were taken and appropriate pre sedation checks were made before any treatment took place.

Are services effective?

The practice ensured that patients were given sufficient information about their proposed treatment to enable them to give informed consent.

Dental care records showed a systematic and structured approach to assessing and planning patient care and treatment. Patient recalls were planned according to National Institute for Health and Care Excellence (NICE) guidelines based on a checklist of risk factors, including oral health history, alcohol and tobacco use. Health education for patients was provided by the dentist and dental hygienists. They provided patients with advice to improve and maintain good oral health.

Are services caring?

Staff were caring and sensitive to the needs of their patients. Patients commented positively on the caring compassionate staff, describing them as friendly understanding and sympathetic.

Patients felt listened to by all staff and were given appropriate information and support regarding their care or treatment. They felt their dentist explained the treatment they needed in a way they could understand. They told us they understood the risks and benefits of each option.

Are services responsive to people's needs?

The practice offered same day appointments for any patient in an emergency.

The practice was responsive the needs of those patients who had high levels of anxiety. A number of patients commented on the way in which staff at the practice had helped them to become more relaxed about attending for treatment and in some cases overcome their fears. This had improved their dental health and encouraged them to have regular oral health checks.

Are services well-led?

The principal dentist with systems in place to maintain clinical governance. The practice had an audit plan and had audited aspects of the service to monitor the quality of the service and to identify areas for improvement.

Staff felt supported and empowered to make suggestions for the improvement of the practice. There was a culture of openness and transparency. Staff at the practice were supported to complete training for the benefit of patient care and for their continuous professional development.

Andover Smile Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by the CQC.

- This inspection was carried out on 15 January 2015. Our inspection team was led by a CQC Lead Inspector the team also included a specialist dental advisor.
- Prior to the inspection we reviewed information we held about the provider. We also viewed information that we asked the provider to send us in advance of the inspection.
- During the inspection we spoke with the principal dentist who is also the registered manager, a dental nurse and the practice receptionist.
- We observed staff interaction with patients and looked around the premises and the treatment rooms.
- We spoke with four patients and reviewed 22 comment cards to obtain their views about the staff and the services provided.
- We reviewed a range of policies and procedures and other documents.
- The specialist dental advisor reviewed a sample of clinical records to assess their quality and structure.

We informed Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

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

Learning and improvement from incidents

There was a system for recording incidents and accidents with guidance for how they should be investigated and reflected upon by the dental practice. Staff told us they were confident about reporting incidents and accidents, although the practice had not had any since they registered with the Care Quality Commission in April 2014 A significant events log was in place should it be needed. The registered manager understood their responsibilities in Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Reliable safety systems and processes (including safeguarding)

Staff had all completed training in safeguarding children and vulnerable adults in March 2013. The practice training log recommended annual training in this subject however this had not taken place. There were prominently displayed contact details for local authority safeguarding teams. All staff were clear about their responsibilities to raise any concerns they may have and felt they could recognise signs of abuse. The principal dentist was the lead professional for safeguarding and staff were aware of this lead role.

Care and treatment of patients was planned and delivered in a way that ensured their safety and welfare. Patients told us and we saw dental care records which confirmed patients were always asked to complete a medical history at the start of each course of treatment. These were rechecked at each subsequent appointment. The dentist was aware of any health or medicines issues which could affect the planning of a patient's treatment. For examples an allergy to latex or any blood thinning medicines. All health alerts were flagged up to staff when the patients' electronic care record was opened.

The practice provided inhalation sedation for patients. (This form of sedation is a mixture of anaesthetic gas and oxygen breathed through a nosepiece. This helps patients to feel relaxed and accept treatment). We found that pre sedation checks took place and patients were asked to bring somebody with them to the appointment and to stay with them afterwards. The dentist appropriately monitored their patient during sedation. This ensured the safety of patients during and after the procedure.

Infection control

In November 2009, and updated in March 2013, the Department of Health published a document called 'Health Technical Memorandum 01-05 Decontamination in primary care dental practices' (HTM 01-05). This document describes in detail the processes and practices essential to prevent the transmission of infections and promote clean safe care. It is used by dental practices to guide them to deliver an expected standard of decontamination.

We saw there were effective systems in place to reduce the risk and spread of infection. During our visit we spoke with the dental nurse and the dentist, who took joint responsibility for infection prevention and control. They were able to demonstrate they were aware of the safe practices required to meet the essential standards of HTM 01-05. They were aware of the need for personal protective equipment (PPE). We observed PPE being used appropriately.

The dental nurse explained accurately the processes and procedures in place to decontaminate instruments. They also described the checks they carried out to ensure the decontamination equipment was functioning properly. We saw records of the checks that were made by staff. Staff also checked the water used for manual cleaning was at the optimum temperature. Visual checks were made of instruments following manual cleaning using an illuminated magnifier. The practice followed the guidelines in HTM 01-05 for the manual cleaning of equipment which meets essential quality requirements.

The dental nurse was able to describe the decontamination procedures in operation within the surgery. They ensured clinical areas were appropriately cleaned between patients and explained the clean and dirty areas in the surgery to ensure the prevention of cross contamination. The practice used single use equipment wherever possible. Cleaning equipment at the practice followed the national guidelines for colour coding. Therefore the equipment could be identified for use in different areas of the practice. Equipment used in high risk areas was stored separately from that used for general and non-clinical areas. The practice had carried out Legionella testing in each of the treatment rooms and had a practice protocol for the management of Legionella. (Legionella is a bacterium that can grow in contaminated water). This included the flushing of dental unit water lines at the beginning and end of the day and between patients. Dental

unit water lines were maintained in accordance with current guidelines. There had been no formal risk assessment of the water supply and there was no system in place to monitor water systems within the building between annual water tests. The practice had started but not completed a premises questionnaire in advance of instructing a contractor to assess the practice. The practice had an infection control policy and had carried out regular audits of their decontamination process and procedures to identify any shortfalls or areas they could improve and work towards best practice. The practice infection control policy covered all aspects of infection prevention and control such as; hand washing, instrument decontamination and storage of instruments. The policy covered minimising blood borne virus transmission and included details of who to contact should a needle stick injury occur. The procedures detailed in the policy related to the practices we observed however the policy had the address of another practice and described a decontamination room which was not present in this building. The provider should update this policy to accurately reflect the layout of this building.

Equipment and medicines

There was a system in place to ensure that all equipment was regularly maintained and serviced. There was a contact list prominently displayed in the office which listed the contractors contact details for the equipment they maintained or tested and the date of their next visit or contract renewal date. This included equipment such as autoclaves (equipment used in the sterilising of instruments), the heating boiler, X-ray machines and portable appliance testing (PAT). Records showed servicing; maintenance and validation of equipment had taken place in accordance with manufacturer's instructions.

The practice kept a supply of emergency medicines which were found to be in date and monitored regularly by staff to ensure they remained safe to use.

The patient records we reviewed showed the prescribing of medicines was recorded. Records showed that quantities, batch numbers and expiry dates of local anaesthetics were always recorded. Medicines kept at the practice were stored securely.

Monitoring health & safety and responding to risks

The practice had carried out a risk assessment in relation to fire safety. There was a record of the maintenance of fire extinguishers which had been carried out in July 2014. The practice was aware their fire alarm service was due in January 2015. Practice meetings had time on the agenda for staff training we saw that a fire drill had formed part of their meeting in March 2014.

Staff were aware of their responsibilities in relation to the control of substances hazardous to health (COSHH), there was a prominently displayed poster in the office as a reminder of the significance of COSHH symbols. This ensured all staff knew how to manage these substances safely.

The practice had minimised risks in relation to used sharps (needles and other sharp objects which may be contaminated) by ensuring that sharps bins were securely attached to the wall in the treatment room. Staff and patients were protected from these items being accidentally knocked over.

Medical emergencies

There were arrangements in place to deal with foreseeable emergencies. We saw that the practice had emergency medicines and oxygen available which may be needed to deal with any medical emergencies should they arise. There was suitable equipment available for dealing with medical emergencies which included an automatic external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. This was in accordance with the recommendations of the Resuscitation Council (UK). Checks were made of the emergency medicines and oxygen to ensure they were in date and ready for use should they be needed.

All staff had taken part in annual basic life support training provided by an external company. They had trained as a team and the training had included medical emergency scenarios which they may encounter. As part of a practice meeting in July 2014 staff had received refresher training about emergency medicines and their use for the safety of patients.

Staff recruitment

The provider kept comprehensive staff files which contained evidence of the checks they had carried out to ensure that staff working at the practice were suitable for their role. The majority of staff had worked for the previous provider of dental services at this practice and had continued to work for the new provider of this service.

Are services safe?

The provider ensured they had satisfactory documentary evidence of the suitability of all the staff, both those they employed directly and those they employed to provide certain treatments for their patients.

Staff files contained evidence of continuous employment with an explanation of any gaps. Criminal record checks by the disclosure and barring service (DBS) had been carried out for all staff and photographic ID was also available. All staff at this practice were qualified and registered with the GDC. There were copies of current registration certificates and personal indemnity insurance. (Insurance they have in place to cover their working practice).

Radiography (X-rays)

The practice had a well maintained radiation protection file. This contained all the information required to satisfy the requirements of the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R 2000) and The Ionising Radiation Regulations 1999 (IRR99).

This file contained details of the radiation protection advisor, the radiation protection supervisor, evidence of the maintenance and critical testing of the X-ray unit. There was a copy of the local rules displayed beside the X-ray set unit which gave staff guidance about the safe use of radiography within the practice. Staff training records showed that all dental nurses had taken part in training relating to radiation regulations within the last 12 months

The dentists at the practice continually assessed the quality of X-ray images. The dentists graded the radiographs (X-rays) they took to monitor their quality and ensure they did not have to be repeated, which could pose a risk to patients. The practice used digital X-rays and aiming devices (these are devices used to ensure the X-ray film and machine are correctly placed) which improved the quality of images. This reduced the number that had to be retaken which protected patients from excess exposure to radiation. There were no recorded actions following the audit to improve quality.

We looked at a sample of dental care records which documented when X-rays had been taken. When X-rays were taken the records showed the reason why they were necessary and recorded any findings. Patients told us the dentist always explained treatment options to them which included why X-rays were required and what they showed.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

The practice ensured patients were given sufficient information about their proposed treatment to enable them to give informed consent. Staff told us how they explained treatment options with their patients including the risks and benefits of each option. We saw these discussions were recorded in dental care records and that patients were provided with a written treatment plan which ensured they were aware of the financial and time commitment of their treatment. Patients were asked to sign a copy of the treatment plan to confirm their understanding and to consent to the proposed treatment. All written consent documents were scanned into the electronic record. Verbal consent to treatment was also recorded on the electronic dental care record.

Patients told us they always felt fully informed about their treatment and they were given time to consider their options before giving their consent to treatment.

Staff had not received specific training in relation to the Mental Capacity Act 2005. However there was a policy available for staff and they were all clear about how they would deal with a situation, should it arise, if they had reason to believe a person lacked the capacity to consent to dental treatment. They were aware of who to consult for support and advice.

Monitoring and improving outcomes for people using best practice

Patients care and treatment was assessed, planned and delivered according to their individual need. We looked at five dental care records which showed a systematic and structured approach to assessing and planning care and treatment.

All patients had a current medical history recorded completed when they attended for examination, and these were updated at each visit. Patients told us the dentist always asked if there had been any changes to medical conditions or any medicines they were taking. This information was recorded in the dental care record with any relevant medical condition highlighted to the dentist by symbols or alerts on the electronic care record. The dentist was aware of any medical issues which could affect the planning of a patient's treatment.

Dental care records enabled us to see the information recorded for each examination. The dentist kept a record of their examination of soft tissues, teeth and other relevant observations. We saw checks of patients gum health was followed up with more in depth assessments for those who would require specialist treatment. Diagnostic tests, such as radiographs (x-rays), were carried out if they were clinically necessary. The results were discussed with the patient. Patients told us they were aware of the dentist carrying out an examination of their whole mouth. They said the dentist explained what they were doing and why.

The dentist explained how they scheduled patient recalls according to National Institute for Health and Care Excellence (NICE) guidelines based on a risk assessment, taking into account a checklist of risk factors, such as alcohol and tobacco use.

Working with other services

The practice referred patients for secondary (hospital) care when necessary. For example for assessment or treatment by oral surgeons. They referred whenever possible to a consultant who was known to them. We saw referral letters contained detailed information regarding the patient's medical and dental history.

The dentist explained the system and route they would follow for urgent referrals if they detected any unidentifiable lesions during the examination of a patient's soft tissues.

Health promotion & prevention

Two dental hygienists worked at the practice, each on a part time basis. The dentist and dental hygienists provided patients with advice to improve and maintain good oral health. Details of discussions between the clinician and their patient were recorded which included diet advice, the use of fluoride paste and rinses and smoking cessation advice.

The dental hygienists focused on treating gum disease and giving advice about the prevention of decay and gum disease including advice on tooth brushing techniques and oral hygiene products. Information leaflets about oral health and various treatments were available at reception. However patients were not able to access these easily and would have to ask reception staff.

Staffing

The practice had systems in place to support staff to be suitably skilled to meet patients' needs. The practice kept a

Are services effective?

(for example, treatment is effective)

record of all training attended to ensure staff had the right skills to carry out their work. The staff carried out annual medical emergencies and basic life support training. They trained together at the practice to ensure they knew their roles and responsibilities should an emergency arise. Records showed staff were up to date with their continuing professional development. (All people registered with the General Dental Council (GDC) have to carry out a specified number of hours of continuing professional development (CPD) to maintain their registration.) Staff records showed professional registration was up to date for all staff and they were all covered by personal indemnity insurance.

The practice provided dental implants which are placed by an implantologist working at the practice one day each month. This dentist worked with their own dental nurse who was trained in this specialist area.

Staffing levels were monitored and staff absences planned for to ensure the service was uninterrupted. Dental nurses worked part time and were flexible in their ability to cover their colleagues at times of sickness. We were told there had been no instances of the dentist working without appropriate support from a dental nurse. However the hygienists who worked at the practice always worked unaccompanied, there was no risk assessment in place for their lone working.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During our visit we spoke with four patients about their care and treatment, we also reviewed 22 comment cards. Patients commented positively about the caring compassionate staff, describing them as friendly understanding and sympathetic. A number of comments related to the way in which staff at the practice had helped patients to be more relaxed about attending for treatment and in some cases overcome their fears. This had improved their dental health and encouraged them to have regular oral health checks.

Patients told us they felt listened to by all staff. We observed reception staff interacting with patients before and after their treatment and speaking with patients on the telephone. Although we were able to hear appointment arrangements being made we did not hear any personal information discussed during our observations in the waiting room. Reception staff were polite and friendly in all situations.

On the day of our visit one dentist was working at the practice. All treatment was carried out with the treatment room doors closed. People's privacy and confidentiality was maintained.

Involvement in decisions about care and treatment

Patients who used the service were given appropriate information and support regarding their care or treatment. Everybody told us the dentist they saw discussed the treatment options that were available to them. They felt that their dentist explained the treatment they needed in a way they could understand. They told us they understood the risks and benefits of each option. Patients were given written treatment plans which clearly documented the proposed treatment and related costs. We looked at the dental records for five patients. The dentist had documented conversations with their patient when treatment options had been decided. Records showed that, when necessary, patients had been given relevant information including the risks and benefits of complex treatment. We saw patients were given verbal and written information about their treatment and after care, for example, when receiving inhalation sedation.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of their patients. This included the provision of general dentistry as well as specialist treatments. Patients were informed of the treatments available through the practice website and by their initial consultation at the practice. Specialist treatment was provided by staff with the appropriate qualifications and experience. Appointment times varied in length according to the proposed treatment and to ensure patients and staff were not rushed. The dentists were supported by two dental hygienists who met the needs of those patients who needed treatment and support to maintain good oral health.

The practice had a number of patients who were provided with sedation for their treatment. The practice had responded to the needs of those patients who found dental treatment stressful. Patients told us the practice had met their needs in this respect and had made their dental treatment more relaxing.

This practice provided treatment privately there was no provision for treatment on the NHS. The practice had developed a number of payment options to meet the needs of those patients who preferred to spread the cost of their treatment.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. Patients we spoke with confirmed this.

Tackling inequity and promoting equality

All the practice facilities were on the ground floor, waiting room, treatment rooms and toilets and were accessible to patients who had mobility difficulties. During a recent refurbishment changes to the building had been made to ease access for patients who may use a wheelchair. This had included widening the entrance door and creating a flat access. Access to the patient toilet had not been improved because building constraints meant it was not possible and therefore it was not accessible for patients who used a wheelchair.

Staff explained how they came into the waiting room to assist and communicate with patients in wheelchairs. The reception desk was at a high level which could create a barrier to patients in wheelchairs.

Access to the service

The practice displayed its opening hours at the entrance to the building. Opening hours were Monday to Wednesday 9am to 4pm and closed for lunch between 12.30pm and 1.30pm. Thursday and Friday 9am to 2pm. Two Saturdays a month the practice opened between 9am and 1pm.

The practice had clear instructions in the practice and via the practice's answer machine for patients requiring urgent dental care when the practice was closed. Information about how to access out of hours treatment was displayed on the entrance door. Staff told us patients were seen as soon as possible for emergency care and always on the same day.

Concerns & complaints

The practice had a Complaint Policy which provided staff with clear guidance about how to handle a complaint. Staff told us how they would raise any comments or concerns immediately with the dentist, who was also the provider of this service, to ensure a timely response was given.

We looked at the practice procedure for acknowledging, recording; investigating and responding to complaints, concerns and suggestions should they be made by patients. However there had been no comments or complaints made by patients since the practice registered with CQC in April 2014.

Information for patients about how to raise a concern or make a complaint was posted on the wall in the reception area. This was difficult for patients to read as it was on the wall behind the reception desk. The practice website contained testimonials from patients but did not offer patients advice about the procedure for making a complaint.

Are services well-led?

Our findings

Leadership, openness and transparency

There was clear leadership in the practice. The principal dentist ensured that human resource and clinical policies and procedures were reviewed and updated to support the safe running of the service. They had also delegated lead roles to suitably qualified and experienced members of staff such as infection control and radiography.

Staff told us there was an open culture at the practice and they felt valued and well supported. They told us the principal dentist, who was the CQC registered manager of this service, was very approachable. There were informal and formal arrangements for sharing information across the practice including general discussions amongst the small staff team at lunchtime or other break times. There were also formal team meetings which included an element of staff training each time. For example refresher training in emergency medicines, the practice safeguarding protocol and fire drill. Staff told us the system of staff meetings and the ethos of continual improvement within the practice helped them keep up to date with new developments, to make suggestions and to provide feedback to the principal dentist.

Governance arrangements

The principal dentist was the CQC registered manager was responsible for the day to day running of the service. They had systems in place to monitor the quality of the service. These were used to make improvements to the service. The principal dentist led on the individual aspects of governance such as complaints, risk management and audits within the practice.

The practice had an audit plan and had audited aspects of the service to monitor the quality of the service and to identify areas for improvement. For example through an audit of their X-rays, infection control procedures, quality of dental impressions and clinical record keeping. A completed audit cycle of record keeping showed an improvement in the quality and content of patient records.

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

Patients who use the service had been asked for their views about their care and treatment. The practice sought continuous patient feedback. A comments box was available in reception and the practice conducted annual patient satisfaction surveys. The most recent survey conducted in February 2014 showed that patients were satisfied with the service and the treatment they had received. 100% of respondents said they were greeted warmly by reception and 98.6% said they definitely felt at ease during their treatment. The most recent surveys had not highlighted any issues or concerns that needed to be addressed.

Staff told us they were always involved in discussions about changes to the practice and were able to make suggestions for improvements at any time. Staff meetings were held approximately every two months. These meetings were recorded and gave all staff the opportunity to make suggestions for improvements to the practice. Recent refurbishments to the practice had been discussed and planned by all staff.

Management lead through learning and improvement

Staff told us they had good access to training and the practice monitored staff training to ensure essential training was completed each year. Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). It is a requirement of the General Dental Council (GDC) that all people registered with them complete a specified number of hours of CPD, including training in medical emergencies, to maintain their registration. Training records showed everyone working at the practice had taken part in basic life support. This training was organised on a regular basis by the practice and included role play and practise of simulated medical emergencies. Staff training was an agenda item for each staff meeting when relevant training took place.

The dentists, dental nurses and dental hygienist working at the practice were registered with the GDC. The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. The practice manager kept a record to evidence that staff were up to date with their professional registration.