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You Smile Dental Care

Inspection Report

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Overall summary

We carried out this announced inspection on 21 November 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We told the NHS England area team and Healthwatch that we were inspecting the practice. They did not have any relevant information to share with us regarding this dental practice.

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 form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

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

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 not providing well-led care in accordance with the relevant regulations.

Background

You Smile Dental Care is situated in the Lincolnshire town of Market Rasen. The practice provides private dental treatment to patients of all ages.

The practice is located on the ground floor with two treatment rooms. There is level access into the practice and the ground floor treatment rooms. There is a pay and display car park a short distance from the practice.

Summary of findings

The dental team includes: one dentist; one part time implantologist; one part time dental hygienist; two qualified dental nurses and one practice coordinator.

We carried out this inspection in response to information of concern received by CQC relating to radiography, equipment and staff recruitment.

The practice is owned by an organisation and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at the practice was the practice manager.

On the day of inspection we collected five completed CQC comment cards. This information gave us a positive view of the practice.

During the inspection we spoke with one dentist, two dental nurses, and the practice coordinator. We looked at practice policies and procedures and other records about how the service is managed.

The practice opening hours are: Monday: 8:30 am to 7 pm; Tuesday: 8:30 am to 7 pm;

Wednesday: 8:30 am to 7 pm; Thursday: 8:30 am to 7 pm and Friday: 8:30 am to 5 pm

Some Saturdays: 9 am to 4 pm by appointment only

Our key findings were:

- The practice was clean and well maintained.
- The practice had infection control procedures which followed published guidance.
- The practice asked patients for feedback about the services they provided, and received positive feedback.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available with the exception of an automated external defibrillator (AED).
- The practice had suitable safeguarding processes. Staff had been trained and knew their responsibilities for safeguarding adults and children.
- The practice had thorough staff recruitment procedures.
- Dental care records within the practice were not always complete.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect
- The appointment system met patients' needs.
- The practice dealt with complaints positively and efficiently.

We identified regulations that were not being met and the provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulations the provider was not meeting are at the end of this report.

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

- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Review its responsibilities to the needs of people with a disability, including those with hearing difficulties and the requirements of the Equality Act 2010.

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?

No action

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

The practice had systems and processes to provide safe care and treatment. They used learning from accidents and complaints to help them improve.

The practice was not receiving patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).

Staff received training in safeguarding and knew how to recognise the signs of abuse and how to report concerns. There was a lead person appointed within the practice for safeguarding matters.

Staff were suitably qualified and the practice completed essential recruitment checks.

The premises and equipment were clean and properly maintained. The practice followed national guidance for cleaning, sterilising and storing dental instruments.

The practice had arrangements and equipment for dealing with medical and other emergencies. There was no automated external defibrillator (AED) or a risk assessment to identify the steps to take to mitigate the risks associated with not having an AED on the premises.

Are services effective?

No action

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

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as professional, helpful and competent. The dentists did not always demonstrate that they took into account guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

The practice supported staff to complete training relevant to their roles and had systems to help them monitor this. Staff had a limited understanding of the Mental Capacity Act and how it would affect dental patients.

Are services caring?

No action

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

Summary of findings

We received feedback about the practice from five people. Patients were positive about all aspects of the service the practice provided. They told us staff were friendly and welcoming. Patients also said their dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

Are services responsive to people's needs?

No action ✓

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

The practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing ground floor treatment rooms for disabled patients and families with children. The practice also had access to telephone interpreter services. The practice did not have an induction hearing loop to assist patients who used a hearing aid.

Are services well-led?

Requirements notice ✗

We found that this practice was not providing well-led care in accordance with the relevant regulations.

The practice had not taken steps to identify and address risks within the practice. There was no system to receive safety alerts from the MHRA. Significant events were not always recorded, and learning from events was limited as a result.

Staff understanding of the Mental Capacity Act and how it related to dental practice was limited

Record keeping was not in accordance with national guidance.

The practice monitored clinical and non-clinical areas of their work to help them improve and learn. This included asking for and listening to the views of patients and staff.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events. Staff knew about these and understood their role in the process. The practice had an accident reporting policy and procedure. When accidents occurred they were investigated and learning points were recorded.

The practice had a system to record, responded to and discuss significant events. This was to reduce risk and support future learning.

Discussions with the principal dentist identified the practice did not receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). The dentist was unaware of these alerts although he said arrangements would be made for the practice to receive MHRA alerts in the future.

Reliable safety systems and processes (including safeguarding)

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. The principal dentist was the identified lead for safeguarding in the practice. They had completed safeguarding training during February 2016.

Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination.

The practice protected staff and patients with guidance available for staff on the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. All COSHH information including a risk assessment and copies of manufacturers' product safety data sheets were stored in a designated COSHH file. The information had been reviewed annually.

We looked at the practice's arrangements for safe dental care and treatment. These included risk assessments which staff reviewed every year. The practice followed relevant safety laws when using needles and other sharp dental items. This included disposable matrix bands and a recognised system for safe handling of needles using single use syringes and needles. In addition it was practice policy that only the dentist handled needles. The dentist used rubber dam in line with guidance from the British Endodontic Society when providing root canal treatment.

The practice had a business continuity plan describing how the practice would deal events which could disrupt the normal running of the practice. A copy was also available off site.

Medical emergencies

Staff knew what to do in a medical emergency and completed training in emergency resuscitation and basic life support every year, with the last training completed in November 2017.

Emergency equipment and medicines were available as described in recognised guidance with the exception of an automated external defibrillator (AED). The practice did not have a risk assessment to identify the steps to take to mitigate the risks associated with not having an AED on the premises. During the last CQC inspection on 18 February 2016 this issue was also raised. Following that inspection the principal dentist told us he would produce a risk assessment and look into purchasing an AED. Staff kept records of their checks to make sure these were available, within their expiry date, and in working order. Equipment included medical oxygen and bag valve masks for both adults and children.

The practice had a first aid box which was located centrally.

Staff recruitment

We saw the practice had a staff recruitment policy and procedure to help them employ suitable staff. The policy reflected the relevant legislation and set out clearly the procedures to be followed when recruiting staff. We looked at five staff recruitment files. These showed the practice followed their recruitment procedure.

We saw that every member of staff had received a Disclosure and Barring Service (DBS) check.

Are services safe?

Clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover. There was a system to monitor that relevant staff were up to date with their registration and indemnity insurance cover.

Monitoring health & safety and responding to risks

The practice's health and safety policies and risk assessments were up to date and reviewed annually to help manage potential risk. These covered general workplace and specific dental topics. The principal dentist was the lead person with overall responsibility for health and safety at the practice. The practice had current employer's liability insurance which was due for renewal on 11 July 2018.

We saw that regular health and safety audits were completed, reviewed and where necessary updated.

The practice had an automatic fire alarm system which was serviced regularly; this included automatic fire detection and emergency lighting. Staff had completed fire training within the practice with copies of training certificates held on file. The fire risk assessment had been reviewed in February 2017.

A dental nurse worked with the dentist and implantologist when they treated patients.

Infection control

The practice had an infection prevention and control policy and procedures to keep patients safe. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. Clinical staff completed an annual update in infection prevention and control. The most recent training having been completed on various dates during 2017.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The records showed equipment staff used for cleaning and sterilising instruments was maintained and used in line with the manufacturers' guidance.

The practice policy identified infection prevention and control audits should be completed twice a year. The latest audit was completed in August 2017. Action plans had been produced following the audits to address issues identified.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment which had been updated in February 2016.

There were records to demonstrate that clinical staff had received inoculations against Hepatitis B and had received boosters when required.

We saw cleaning schedules for the premises. The practice was clean when we inspected and patients confirmed this was usual.

Equipment and medicines

The Care Quality Commission (CQC) received information of concern relating to the routine testing of equipment in the practice. The records in the practice and discussions with the principal dentist showed these concerns to be unfounded.

We saw servicing documentation for the equipment used. Staff carried out checks in line with the manufacturers' recommendations. There were records within the practice to demonstrate that equipment had been serviced regularly.

The practice had suitable systems for prescribing, dispensing and storing medicines.

Radiography (X-rays)

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and had the required information in their radiation protection file.

The practice had one intraoral X-ray machine which was fitted with rectangular collimation to reduce the dose of radiation to patients. There was also one panoramic dental X-ray machine (OPG) to take X-rays of the entire jaw. The practice used digital X-rays to further reduce the dose of radiation received by patients.

The OPG was situated in an open area beneath the stairs in the practice. We saw the practice had received advice from the Radiation Protection Advisor regarding the siting of the

Are services safe?

machine. This advice was recorded within the critical examination completed on installation, and identified the steps to take to reduce risks. Discussions with the dentist and observations showed the advice was being followed to ensure these X-rays were being taken as safely as possible.

We saw evidence that the dentists justified, graded and reported on the X-rays they took. The practice carried out radiography audits every year following current guidance and legislation. The last X-ray audit was completed between July 2017 and November 2017. An action plan had been produced which identified learning points.

Clinical staff completed continuous professional development in respect of dental radiography as required by the General Dental Council (GDC).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept dental care records containing information about the patients' current dental needs, past treatment and medical histories. Clinical notes were held electronically with radiographs and medical history forms inserted into the dental record. We saw examples of dental care records that did not identify the discussions and advice given to patients in relation to their dental health by the various dental care professionals at the practice. We also noted gaps in the dental care records where information was missing or had not been recorded.

We saw that the practice audited patients' dental care records to check that the dentist recorded the necessary information. We noted the audits were ineffective as they had not identified that dental care records were incomplete or proposed a course of action to address this.

Health promotion & prevention

Discussions with the dentist and a sample of dental care records showed there was some evidence of oral hygiene advice being given to patients. There was little or no evidence to demonstrate that oral hygiene and preventative advice had been given in the dental care records we saw. This included a child who had received orthodontic treatment.

The dentist told us they discussed smoking, alcohol consumption and diet with patients during appointments. We saw limited evidence of this in dental care records. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health. Complimentary samples of toothpaste and mouthwash were available at reception.

Information posters and leaflets were available for patients to read in the waiting room. There was also a television available to give information about treatments and positive oral health messages.

Staffing

The practice had one dentist; one part time implantologist; one part time dental hygienist; two qualified dental nurses and one practice coordinator.

We checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

Staff new to the practice had a period of induction based on a structured induction programme. We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council.

We saw that staff appraisals had been completed annually.

Working with other services

The dentist confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. These included referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by the National Institute for Health and Care Excellence (NICE) in 2005 to help make sure patients were seen quickly by a specialist. The practice monitored urgent referrals to make sure they were dealt with promptly.

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment. There was a consent policy which referenced the Mental Capacity Act (MCA) 2005 and guidance relating to the treatment of young people aged under 16 years. We discussed consent with a number of staff who showed a limited understanding and knowledge of the MCA and treating young people aged under 16. The dentist told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients who completed CQC comment cards said their dentist listened to them and gave them clear information about their treatment. We saw the dentist had not consistently recorded this information in dental care records.

Patients were given a copy of their treatment plan and the practice recorded consent within the patient dental care records. Dental care records for patients who had received implants identified a short time frame between the pre-operative discussion and the procedure being completed in some cases as short as a week. This short time frame could impact on the patients' ability to consider the risks and benefits and therefore give valid consent.

Are services effective?

(for example, treatment is effective)

We saw little evidence of risks and benefits being discussed with patients other than short term surgical complications. For example we saw the records for one patient who was a smoker. There is evidence to suggest the success rate is significantly lower in patients who received implants and who smoked. We saw no evidence that this had been explained to the patient. For example records said “advice given” but there was no detail of what that advice was. As we had identified there was a short time frame between the pre-operative discussion and the procedure being completed, if advice was given to stop smoking and the gap between consultation and implant placement was very brief this would be unlikely to change the patient’s smoking status.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with reception staff who were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were caring, gentle and good. We saw that staff treated patients with respect, were welcoming and friendly at the reception desk and over the telephone.

Nervous patients said staff were compassionate and understanding.

Staff were aware of the importance of privacy and confidentiality. Staff told us that if a patient asked for more privacy they would take them into another room. The reception computer screens were not visible to patients and staff did not leave personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. Computers were password protected.

Involvement in decisions about care and treatment

The costs for private dental treatment were displayed at reception and on the practice website.

The practice gave patients clear information to help them make informed choices about their treatment options. Patients confirmed that staff listened to them, did not feel rushed and were able to ask questions.

Patients told us staff were helpful and understanding when they were in pain, distress or discomfort.

The practice's website provided patients with information about the range of treatments available at the practice. These included general dentistry and treatments including dental implants, cosmetic dentistry and dentures provided by this practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice had an efficient appointment system to respond to patients' needs. Several patients commented on the ease of getting an appointment that suited their needs. Patients told us they found it easy to get an appointment and staff were helpful and accommodating when making appointments. Some patients commented positively about being seen at short notice when in pain or in an emergency. Staff told us that patients who requested an urgent appointment were seen the same day. Patients told us they had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting. Each dentist made emergency appointment slots available each day or patients could come and sit and wait to be seen.

Staff told us that they texted patients who had signed up for the service 24 hours before an appointment was due.

Promoting equality

The practice made reasonable adjustments for patients with disabilities. There were two treatment rooms situated on the ground floor and therefore accessible to patients who used wheelchairs and families with pushchairs. The toilet facilities were compliant with the requirements of Equality Act 2010. The practice had completed an access audit to formally assess patients' needs.

The practice leaflet was available in a large print format. Staff said there were arrangements for accessing an interpreter or translation service though this had not been needed in the past.

The practice did not have an induction hearing loop to assist patients who used a hearing aid. The Equality Act 2010 suggests hearing loops should be available in public places such as dental practices.

Access to the service

The practice displayed its opening hours on their website and outside the practice.

This included the different options for access to emergency treatment outside of opening hours.

We confirmed the practice kept waiting times and cancellations to a minimum.

The practice was committed to seeing patients experiencing pain on the same day and kept appointments slots free for same day appointments. The answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was closed. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Concerns & complaints

The practice had a complaints policy providing guidance to staff on how to handle a complaint. The practice displayed a detailed procedure in the waiting room which explained how to make a complaint and identified other agencies patients could contact should they remain dissatisfied. The principal dentist was responsible for dealing with complaints in the practice. Staff told us they would tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

Staff told us they aimed to settle complaints in-house and invited patients to speak with them in person to discuss these.

We looked at comments, compliments and complaints the practice received in the year up to this inspection. We saw that the complaints had been handled in line with the practice complaints policy and actions and learning points identified.

Are services well-led?

Our findings

Governance arrangements

The principal dentist had responsibility for the management and leadership of the practice together with the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

The practice had policies, procedures and risk assessments to support the management of the service and to protect patients and staff. These included arrangements to monitor the quality of the service and make improvements. We saw that policies and risk assessments had been reviewed at the beginning of the calendar year.

There were no arrangements to receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA).

The practice did not have an automated external defibrillator (AED) or a risk assessment to detail how they would manage the risk this posed to patient safety in the event of a medical emergency. This had been identified at a previous CQC inspection on 18 February 2016, and the principal dentist had said a risk assessment would be produced. This had not happened.

We saw the practice did not follow guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

Leadership, openness and transparency

Staff were aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong. Staff were prompted to offer an apology when things had gone wrong. Discussions with staff identified they understood the principles which underpinned the duty of candour.

Staff said they were encouraged them to raise any issues and felt confident they could do this. They knew who to raise any issues with and told us that the principal dentist was approachable, would listen to their concerns and act appropriately. If staff had any concerns these were discussed at staff meetings.

The practice held regular meetings where staff could raise any concerns and discuss clinical and non-clinical updates. Meetings were minuted and those minutes were available to all staff.

Learning and improvement

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, infection control and radiography. We saw that some audits had been evaluated and feedback provided to the relevant clinician. We identified some examples of a lack of information being recorded in dental care records which had not been identified or addressed by the audit.

Staff showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. The whole staff team had annual appraisals and we saw evidence of completed appraisals in the staff folders.

Staff told us they completed essential training, including medical emergencies and basic life support, each year. The General Dental Council requires clinical staff to complete continuous professional development.

We saw evidence that staff were completing a range of training courses, and this was supported by the practice to ensure the development of staff skills.

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

The practice used a range of means including patient surveys and verbal comments to obtain staff and patients' views about the service.

There was a comments box in the waiting room for patients to provide feedback. The results were analysed and showed that patients had consistently provided positive feedback over the previous four years.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations **How the regulation was not being met:** • The provider did not have systems to enable them to continually monitor risks and to take appropriate action to mitigate risks, relating to the health, safety and welfare of patients and staff. • The provider did not have an automated external defibrillator (AED) or risk assessment to manage medical emergencies taking into account guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team. • The provider did not receive patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).

This section is primarily information for the provider

Requirement notices

- The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user.

- The provider had failed to use the audit process effectively to address shortcoming identified in the dental care records.