The Hygienist Limited

The Hygienist Limited

Inspection Report

Newmarket Street
The Old Market
Hereford
HR4 9HR
Tel: 01432 343380
Website: www.thehygienist-hereford.co.uk/

Date of inspection visit: 15 August 2016
Date of publication: 30/09/2016

Overall summary

We carried out an announced comprehensive inspection on 15 August 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 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 providing well-led care in accordance with the relevant regulations.

Background

In May 2013 the General Dental Council changed the regulations on how patients can access treatment with a dental hygienist. The change of regulations means that dental hygienists are permitted to see patients directly in order to undertake care and treatment within their scope of practice without a referral from a dentist. This arrangement is known as 'direct access'.

The Hygienist opened in 2015 and is situated in a new retail development in Hereford city centre. It provides direct access private dental hygienist treatment. The practice is not a general dental practice and does not provide general dental treatment. It does offer tooth whitening in line with relevant direct access guidance from the General Dental Council (GDC). This is carried out under prescription from a dentist who visits the practice to complete the necessary assessment before the dental hygienist provides the treatment. The dentist is also present at the practice for patients' first whitening treatment.

The dental hygienist who established the practice told us their aim was to extend patient choice and provide a flexible service aimed at helping patients to improve their oral hygiene.

The dental hygienist is the director of the company and the registered manager. A registered manager is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

The practice has one dental hygienist (the registered manager) who is supported by a dental nurse. The dental nurse also carries out reception and administrative duties.

The practice has one dental treatment room and a decontamination room for the cleaning, sterilising and packing of the instruments used in dental hygiene treatments. There is level access and double doors from the pavement into the practice. The patient toilet is on the ground floor and is equipped for patients with physical disabilities.

The practice is open from 9.30am to 5pm from Monday to Friday and 9.30am to 1pm on Saturdays (information on the practice website highlighted that the practice charged a £5 surcharge for Saturday appointments).

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 20 completed cards, met one patient during the inspection and saw patients' comments on social media and in the practice's own patient survey results.

Our key findings were:

- The practice and had systems to assess and manage infection prevention and control. The premises were visibly clean and patients commented on the high quality of the surroundings.
- The practice had suitable safeguarding processes and staff understood their responsibilities for safeguarding adults and children.
- The practice had clear processes for dealing with medical emergencies and for ensuring that dental equipment was available and regularly maintained.
- Dental hygienist treatment records provided clear and detailed information about patients' care and treatment.
- Staff received training appropriate to their roles and were supported in their continued professional development.
- The practice provided a direct access service in line with guidance from the General Dental Council. This included clear referral systems, arrangements for working under prescription from a dentist when providing tooth whitening and suitable arrangements for the management of medicines including local anaesthetics.
- Patients were able to make appointments when needed.
- The practice had established a variety of ways to gather patients' views including in-house surveys and social media.
- Patients received a flexible and responsive service and staff treated them in a caring, respectful and professional way.
- The practice had governance processes to manage the practice effectively.
- The practice had a strong focus on supporting and encouraging patients to improve their oral health. They used patients' appointments, social media and regular competitions to promote oral hygiene and to educate patients. This is notable practice because it shows a commitment to encouraging improved oral health for their patients and the wider community.

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

- Review the practice's recruitment arrangements so an effective process which reflects relevant legislation and guidance is in place for future staff appointments.
- Review whether the practice should register with the Information Commissioner.

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 took safety seriously and had systems for managing this. These included policies, procedures and risk assessments for important aspects of health and safety. These included infection prevention and control, serious incident reporting, waste management and validation, maintenance and testing of equipment. Staff were aware of their responsibilities for safeguarding children and adults. Contact information for local safeguarding professionals and relevant policies and procedures were readily available for staff to refer to if needed. The practice had patient group directives signed by a dentist to allow them to administer local anaesthetics. Tooth whitening was provided under prescription from a dentist in line with direct access guidelines from the General Dental Council.

No action

Are services effective?

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

The practice provided personalised dental hygienist care and treatment. The dental hygiene care records we looked at provided clear and detailed information about patients' care and treatment. Clinical staff were registered with the General Dental Council and completed continuous professional development to meet the requirements of their professional registration. The registered manager worked within the scope of practice of their professional registration and referred or signposted patients to other dental or health services as needed. The information we gathered confirmed that the practice provided care and treatment to patients in accordance with published guidance. Staff understood the importance of obtaining informed consent, including when treating patients who might lack capacity to make some decisions themselves.

No action

Are services caring?

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

We gathered patients' views from 20 completed Care Quality Commission comment cards, spoke with one patient during the inspection and looked at comments from patients on social media. All the information we gathered provided a positive view of the service the practice provided. Patients found the practice team to be professional, friendly and helpful. They said they received a caring service and that the registered manager gave them detailed information about their treatment. During the inspection we saw staff speaking with patients on the telephone and in person; they were polite, warm and welcoming in each case. Patients confirmed they were treated with respect.

No action

Are services responsive to people's needs?

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

No action

Summary of findings

All the information from patients that we looked at showed high levels of satisfaction with how flexible and responsive the practice was.

There was level access and double doors from the pavement into the practice. The patient toilet was on the ground floor and equipped for patients with physical disabilities. The practice had a hearing loop and headset and braille signs to assist patients who used these.

Information was available for patients at the practice and on the practice website. The practice had a complaints procedure which was available for patients; they had not received any complaints in the year they had been open.

Are services well-led?

No action 

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

The practice had arrangements for managing and monitoring the quality of the service. These included relevant policies, systems and processes which were available for staff to refer to. Audits of clinical and other systems and processes had been established at the practice to help monitor the quality of the service provided.

The practice team valued learning and development as a means to improving the quality of the service. They had established a structured appraisal process and held monthly staff meetings.

The practice took the views of patients seriously and used patient surveys, a suggestion box and social media to gather patients' views.

The Hygienist Limited

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.

The inspection was carried out on 15 August 2016 by a CQC inspector with remote support from a dental specialist adviser. Before the inspection we reviewed information we held about the provider and information that we asked them to send us in advance of the inspection.

During the inspection we spoke with the registered manager and with the dental nurse who also provided reception and administrative support. We looked around the premises including the decontamination room and treatment room. We viewed a range of policies and procedures and other documents and read the comments made by 20 patients in comment cards provided by CQC before the inspection. We also met one patient during the inspection and saw patients' comments on social media and in the practice's own patient survey results.

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

No notifiable incidents or accidents had taken place at the practice since they opened but the practice had set up systems in readiness for any they may need to report in the future.

There was a significant event policy to provide guidance to staff about the types of incidents that should be reported as significant events and under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Information about incidents notifiable to CQC was displayed on the staffroom wall. The practice had a suitable accident reporting book and significant event forms for staff to use.

The practice had a safety incident reporting policy and information for staff about national incident reporting arrangements. The practice explained that they received updates about national safety issues from the Dental Hygienist Association. They had not subscribed to the government website to obtain immediate updates about alerts and recalls for medicines and medical devices. They did this during the inspection.

The practice was aware of the legal requirement, the Duty of Candour, to tell patients when an adverse incident directly affected them. This duty was explicit in their policies and reporting forms.

Reliable safety systems and processes (including safeguarding)

The registered manager and dental nurse were aware of how to recognise potential concerns about the safety and well-being of children, young people and adults whose circumstances might make them vulnerable. They had completed suitable safeguarding training for their roles.

The practice had up to date safeguarding policies and procedures based on local and national safeguarding guidelines. These included specific safeguarding significant event forms and charts for recording concerning facial marks. The contact details for the relevant child and adult safeguarding professionals in Herefordshire were readily available. Safeguarding information was also available for patients to refer to. The registered manager was the named safeguarding lead.

The practice was working in accordance with the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and the EU Directive on the safer use of sharps which came into force in 2013.

Medical emergencies

The practice had arrangements to deal with medical emergencies at the practice. The practice had 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 saw evidence that the registered manager and dental nurse had both completed medical emergencies management training and training in how to use the defibrillator. Refresher training was booked for November 2016.

The practice had the emergency medicines as set out in the British National Formulary guidance. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines. The staff kept records of the emergency medicines and equipment to monitor that they were available, in date, and in working order.

The emergency medicines box was extremely well organised with individual labelled boxes for items needed for specific types of medical emergency, for example, diabetes, epilepsy and asthma. The practice had done this to make the items easier to find in the kit when needed urgently. They had supplemented this with laminated cards for the most common types of medical emergency that might arise. The practice's supply of medicine used to treat patients having an epileptic fit was a pre-measured system with doses prepared according to the patient's age. The practice also had access to a 24 hour emergency first aid responder and a second defibrillator kept in the retail development where the practice was located.

The practice had Glucagon available. This is a medicine for patients needing urgent first aid for seriously lowered blood sugar, particularly patients with diabetes. This was stored out of the refrigerator. The practice was not aware they needed to adjust the expiry date accordingly although the Glucagon was still in date. The practice amended the date and ordered a new one so they would have it when the expiry date was reached.

Staff recruitment

Are services safe?

The practice had a basic recruitment policy but this did not provide a sufficiently structured recruitment process. The only person employed had been well known to the registered manager when they recruited them. This was because they had previously worked together for over 10 years at a general dental practice. We looked at their recruitment records and saw that the majority of the required information was available. This included a Disclosure and Barring Service (DBS) check. The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Some information such as a full employment history and reasons for leaving previous relevant employment was not recorded. The registered manager had known all of this information although they had not kept written information about this. They told us they would establish a structured recruitment policy and procedures based on relevant legislation so this would be in place before the recruitment of any new staff.

The practice had evidence that the staff were registered with the General Dental Council (GDC) and that their professional indemnity cover was up to date and were using annual appraisals to ensure this was confirmed.

Monitoring health & safety and responding to risks

The practice had a number of health and safety related policies and procedures and specific risk assessments covering a variety of general and dentistry related health and safety topics. These were supported by a detailed business continuity plan describing how the practice would deal with a wide range of events which could disrupt the normal running of the practice. The registered manager had this on their laptop so they could always access it and a copy was pinned up in the staff room in case it was needed urgently.

The practice had a fire risk assessment completed by an external fire safety consultant. Staff kept records of the routine checks they made of the various fire safety precautions. Arrangements for many aspects of fire safety in the building were the responsibility of the landlord and others were the responsibility of the practice. The registered manager was clear about their individual and shared responsibilities and explained that the site management team were exacting in making sure fire safety arrangements were followed as expected.

The practice had detailed and well organised information about the control of substances hazardous to health (COSHH).

The practice benefitted from a security service provided by the landlord for the whole of the retail development where it was situated. This included twice daily visits by one of the on-site security team and an 'early warning' system about any adverse incidents within the development.

Infection control

The dental nurse carried out the general cleaning of the building in hours that were in addition to their other duties. The practice was visibly clean and tidy. They had a written cleaning schedule which they used to record that they had completed all the necessary cleaning tasks. Patients who mentioned cleanliness in CQC comment cards were positive about this.

The practice had an infection prevention and control (IPC) policy and the dental nurse was the IPC lead for the practice. We saw that the practice had completed six monthly IPC audits looking at all aspects of hygiene and cleanliness and that the dates for the audits in 2017 were already planned. The practice did not have a copy of the Department of Health's Code of Practice on the prevention and control of infections and related guidance; they made a note of the details and said they would download this and use it to review their IPC policy. The IPC audits in 2016 had identified a need for a different design of sharps container and the need to monitor waste arrangements as patient numbers increased. We saw information to show that both had been carried out.

The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. Staff showed us the practice's processes for the cleaning, sterilising and storage of dental instruments and we reviewed their policies and procedures. We found that they met the HTM01- 05 essential requirements for decontamination in dental practices.

Decontamination of dental instruments was carried out in a separate decontamination room. The separation of clean and dirty areas in the decontamination room and in the

treatment room was clear. The practice had suitable arrangements for moving used and clean instruments between the decontamination room and the treatment room.

The dental nurse showed us the decontamination process and explained this clearly. The practice kept records of the expected decontamination processes and checks including those which confirmed that equipment was working correctly. The autoclave was computerised so that data about each sterilisation cycle was available. The practice had been recording their visual checks but not downloading the computer information. They did this during the inspection and confirmed they would do so weekly in future. We saw that instruments were packaged, dated and stored appropriately and that the practice used single use instruments whenever possible.

The practice had personal protective equipment (PPE) such as heavy duty gloves, disposable gloves, aprons and eye protection available for staff and patient use. The treatment room and decontamination room had designated hand wash basins for hand hygiene and liquid soaps and paper towels.

The practice had a Legionella risk assessment carried out by a specialist company in July 2015. Legionella is a bacterium which can contaminate water systems in buildings. This did not identify that any remedial work was needed. We saw that staff carried out routine water temperature checks and kept records of these. The practice used an appropriate chemical to prevent a build-up of potentially harmful biofilm in the dental waterlines and used a testing regime certified by the manufacturer of the chemical. Staff confirmed they also carried out regular flushing of the water lines in accordance with current guidelines.

The practice used distilled water in equipment used for cleaning and sterilising instruments. They confirmed that they generally used each batch they made within one to two days. They had records showing the date which each batch was distilled which confirmed this. Although they used it much faster we noted that they had recorded a one month expiry date for each batch. We highlighted that HTM01-05 states that any water unused or left in opened containers at the end of the day should be discarded (paragraph 17.4). Similarly the practice had recorded use by dates for the solution of chemical used in the dental unit water lines which were longer than those in the manufacturer's instructions. The practice corrected both issues before we left the practice.

The segregation and storage of dental waste reflected current guidelines from the Department of Health. The practice had a waste management policy and used an appropriate contractor to remove waste from the practice. This company had informed them that because they provided a registered manager only service only their dental sharps were classified as hazardous waste. The practice had appropriate documentation available for the collection of waste. We saw that the practice was able to store their general waste securely in a secure area within the retail development ready to be collected. They showed us they kept sharps secure within the practice building until collection.

The practice had a process available for staff to follow if they accidentally injured themselves with a needle or other sharp instrument and staff were aware of what to do. The practice also had information for patients about having a blood test if staff injured themselves with an instrument used for that patient. The practice had documented information about the immunisation status of each member of staff. The practice had a spillage kit available to deal with any bodily fluids they may need to clean up.

Equipment and medicines

The practice had maintenance arrangements for equipment to be maintained in accordance with the manufacturers' instructions using appropriate specialist engineers. This included equipment used to sterilise instruments, the emergency oxygen supply, the compressor and portable electric appliances.

The registered manager administered local anaesthetics under patient group directions (PGD) signed by a dentist in line with guidance for direct access from the General Dental Council. A PGD is a written instruction which allows listed healthcare professionals to sell, supply or administer

named medicines in an identified clinical situation without the need for a written, patient-specific prescription from an approved prescriber. The registered manager recorded the type of local anaesthetic used, the batch number and expiry date in patients' dental care records. Apart from local anaesthetics and the medicines for medical

emergencies described above the practice did not issue or prescribe any medicines. They had a PGD for fluoride applications and toothpaste but had not yet provided either to any patients.

Radiography (X-rays)

The practice did not have equipment for taking X-rays. The registered manager explained that if they judged that a patient had dental concerns that required further assessment and diagnosis, (including X-ray information), they advised them to make an appointment to see their own dentist or made a written referral to the local NHS dental access centre if they did not have one.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The registered manager confirmed they provided treatment based on published guidelines such as those from the National Institute for Health and Care Excellence (NICE). They took their professional role seriously and explained they were meticulous in ensuring that they worked within the scope of practice of their registration with the General Dental Council (GDC).

The registered manager assessed patients' oral hygiene and provided a range of treatments from basic cleaning and polishing through to root surface debridement (RSD) for patients with significant problems with their gum health. They also carried out tooth whitening treatments under prescription from a dentist who visited the practice to assess patients' suitability for this. This dentist was also available at the practice during patients' first treatment as required under GDC direct access guidance. Although most of the practice's patients were adults they also saw some children. The registered manager explained that these was often children who needed additional support with oral hygiene before and during orthodontic (tooth straightening) treatments.

The registered manager kept suitably detailed records about the treatments they provided. This included recording a basic periodontal examination (BPE); this is a simple and rapid screening tool used by dentists and dental hygienists to indicate the level of treatment need in relation to a patient's gums. The registered manager completed this check during each patient's first and subsequent appointments. They also carried out six point pocket charting for patients with more significant problems with their gums. The practice had completed a random audit of eight patients' records which found that all of the expected information was recorded in every case.

The practice obtained and regularly updated details of patients' medical history.

We met a patient during the inspection who told us how pleased they were with the treatment they had just had and that they planned to recommend the service to a relative. Feedback from patients was positive about the impact their treatment at the practice had had on their oral health and appearance.

Health promotion & prevention

The practice was aware of and took into account the Delivering Better Oral Health guidelines from the Department of Health. Information was available for patients about oral health, stopping smoking and sensible alcohol consumption. The dental hygienist provided patients with advice about the impact of diet, smoking and alcohol consumption as an integral part of each consultation and treatment with the aim of supporting them to improve their overall oral health and general well-being.

The practice had found that many of their patients used their services because they felt less anxious there than at a general dental practice. They told us that they actively encouraged patients to see a dentist especially when they had gone for many years without doing so.

The practice had a strong focus on supporting and encouraging patients to improve their oral health. They used each appointment to promote oral hygiene and to educate patients about the impact of nutrition, smoking and alcohol consumption. They used social media to provide information to patients as well as to promote the business. For example in recent months they had posted information about the results of poor oral hygiene, National Smile Month, sugar in soft drinks, a toothbrush amnesty for children and correct tooth brushing technique. The practice ran regular competitions with oral and general health related products as prizes. A recent competition had also included a fitness tracker. The registered manager explained that this was part of their ethos to encourage overall good health for patients. Another initiative had involved the provision of oral health sessions for children at a village school in line with the content of the national curriculum. Sessions included talking to children about correct tooth brushing, 'good food/bad food' and hidden sugars in food and drinks. They said they hoped to expand this to other schools in the future. The retail development ran occasional seasonal events such as a Halloween trail. The practice took part in this and provided sugar free treats for children who took part.

Staffing

This was a small practice which currently had one dental hygienist (the practice manager) and one dental nurse/ receptionist. This meant that the registered manager often worked without chairside assistance from the dental nurse.

Are services effective?

(for example, treatment is effective)

They explained that now they had been open for a year and had a steadily increasing patient list they intended to recruit a receptionist so they could have chairside support from a dental nurse for most appointments. Their preference was to appoint someone who was also qualified as a dental nurse to provide an effective skill mix. In the meantime the registered manager and dental nurse co-ordinated their time off so that the dental nurse was always on the premises to assist when needed.

The registered manager supported the dental nurse to complete the continuing professional development (CPD) required for their registration with the General Dental Council (GDC). The practice had evidence that all clinical staff held current GDC registration. The dental nurse had received a recent annual appraisal and showed us their well maintained CPD folder.

As well as clinically focused training staff had also completed safety related training such as basic life support and defibrillator training, fire safety and infection control. The practice had a structured induction process ready for use when they were joined by any new staff. The registered manager and dental nurse had also used this when they first set the practice up.

Working with other services

Whilst the registered manager primarily checked and treated patients' gum health they were alert to other dental problems and potential signs of mouth cancer. They told us they took care to work only within their scope of practice. The practice had a written referral policy which described the process they followed when a referral to another dental or healthcare professional was necessary

If they identified any potential concerns such as tooth decay they approached this according to the patient's circumstances. They advised patients who attended a general dental practice regularly to make an appointment with their dentist. If a patient did not have a dentist and was in pain or had obvious signs of problems with their teeth they made direct referrals to the local NHS dental access centre.

The practice referred patients with other potential oral health concerns to the oral health department at their local hospital. We noted that one patient had written on a social media site that the practice had made such a referral for them. As a result they had been reassured about a possible health issue. The practice referred patients for investigations in respect of suspected oral cancer in line with NHS guidelines.

The practice policy was to provide patients with a copy of any referral letter or referral form. This provided the patient with information about the reasons for the referral. The practice policy included information about obtaining patients' consent for referring to other professionals. They asked patients to let them know if they had not received an appointment within a suitable timeframe. Referral letters were sent by signed delivery to ensure they arrived. oral department at Hereford hospital and the

If patients did not have a dentist the practice gave them a list of dentists in Herefordshire in order to encourage them to have a full dental assessment but did not make specific recommendations.

The practice had an arrangement with a local dentist to come to the practice to do the necessary pre-treatment assessment and prescription for tooth whitening. This dentist had also completed patient group directions to allow the registered manager to administer local anaesthetics.

Consent to care and treatment

The registered manager and dental nurse understood the importance of obtaining and recording consent and giving patients the information they needed to make informed decisions about their treatment. They also understood the requirement to obtain consent when making referrals to other services. The registered manager recorded their discussions with patients about treatment in their records. For basic cleaning appointments we saw evidence that the registered manager recorded verbal consent in the patient notes. We also saw evidence of more detailed treatment plans provided to patients having more complex treatment such as root surface debridement (RSD). We saw examples of treatment plans showing that the risks, benefits and costs were clearly set out for patients. The practice had completed a random audit of eight dental hygiene care records which confirmed that consent was recorded in each case.

The practice had a written consent policy and guidance for staff about the Mental Capacity Act (MCA) 2005.The MCA provides a legal framework for health and care

Are services effective?

(for example, treatment is effective)

professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The registered manager understood the relevance of this legislation in dentistry. They confirmed that they had not yet had any patients where they had needed to take this into account when gaining consent.

The registered manager was also aware of and understood the legal framework they must follow when considering whether young people under the age of 16 may be able to make their own decisions about care and treatment. They told us that they always recorded the name and relationship of the adult present when they treated children although most of their patients were adults.

The practice also gained written consent from patients in respect of communicating with them using texts and email and about leaving messages for them by telephone.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We collected 20 completed CQC comment cards, met one patient and looked at comments made about the practice by patients on social media. All the information showed that patients had a consistently positive view of the service the practice provides. All the information we gathered showed that the practice provided a caring service. Patients described the practice team as professional, friendly and helpful. During the inspection we saw staff speaking with patients on the telephone and in person; they were polite, warm and welcoming in each case. Patients confirmed they were treated with respect.

The reception desk was situated in the same room as the waiting area. Staff explained that if a patient asked for more privacy to discuss something they would take them into another room. We saw that the reception computer screen was not visible to patients and that no personal information was left where another patient might see it.

The practice had a confidentiality policy and a consent form for patients in respect of communication with them by telephone, text and email.

Involvement in decisions about care and treatment

A number of patients who filled in CQC comment cards wrote that the practice gave them detailed information before and during their treatment. Patients commented that the registered manager listened to them, made them feel comfortable and reduced their anxieties about having dental hygiene treatment. The practice provided written treatment plans for more complex treatments and used written consent forms for certain procedures.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The registered manager told us they established the practice to provide additional choice for patients wanting or needing treatments provided by a dental hygienist. They had wanted to extend patient choice and to provide a flexible service aimed at helping patients improve their oral hygiene. We discussed the type and range of treatment provided at the practice. These included general cleaning and polishing and more extensive treatments such as root surface debridement (RSD) for people with more significant treatment needs. They also provided tooth whitening under prescription from a dentist.

The registered manager told us that when they opened the practice they had expected that most patients that came to them would not have a dentist. In practice they had a mix of patients 90% of whom did have an existing dentist. They said there seemed to be several reasons for patients nevertheless coming to them for treatment. Some patients' dentists did not have a dental hygienist or they only worked on certain days, some patients found it difficult to make appointments that suited them and others seemed to prefer going somewhere different for their dental hygienist care.

We collected 20 completed CQC comment cards, met one patient and looked at comments made about the practice by patients on social media and in the practice's audit of 20 patient survey forms. Patients were complimentary about the practice and many commented on the impact their treatment had on their appearance and general sense of well-being.

Tackling inequity and promoting equality

Staff told us that they had not yet had any patients who were not able to converse confidently in English but had access to an interpreting service to assist with communication if needed. The registered manager confirmed this also included British Sign Language interpreting. The practice was exploring the use of translation software for their computer system so they could translate written information for patients in a wide range of languages whenever needed.

The practice had an induction hearing loop to assist patients who used hearing aids and a microphone and headset for patients with hearing difficulties who did not use hearing aids. Braille signs were fixed to doors in the practice for blind patients.

There was level access and double doors from the pavement into the practice. The patient toilet was equipped with grab rails for patients with physical disabilities and was large enough for use by patients who used wheelchairs. There was a low level wash hand basin and an alarm call system was installed.

Access to the service

The practice was open from 9.30am to 5pm from Monday to Friday and 9.30am to 1pm on Saturdays (information on the practice website highlighted that the practice charged a £5 surcharge for Saturday appointments). Patients commented said appointments were easy to obtain and convenient. We talked about the appointment booking system with the dental nurse/receptionist. They told us that appointments were booked according to the treatment a patient would be receiving and lasted from 30 minutes to two hours. They explained that the registered manager liked to have sufficient time to spend with patients in an unhurried way and without keeping the next person waiting. During the inspection we heard the team booking appointments for existing and new patients. On each occasion they asked the patient when would be most suitable for them.

There was information for patients on the practice website about the treatments provided and the charges for these.

The practice did not provide out of hours emergency cover because dealing with dental emergencies such as tooth ache and abscesses is not within a dental hygienist's scope of practice under their registration with the General Dental Council (GDC).

Concerns & complaints

The practice had a complaints policy and procedure and a copy of this was available for patients at the practice but not on the practice website. The procedure explained who patients should contact about concerns and how the practice would deal with their complaint. The procedure

Are services responsive to people's needs?

(for example, to feedback?)

also contained contact details for the GDC and the Dental Complaints Service, national organisations that patients could raise their concerns with. The practice had not received any complaints during their first year of operation.

Are services well-led?

Our findings

Governance arrangements

The dental hygienist was the registered manager and took a lead role in the day to day management of the practice as well as their clinical role. They delegated some responsibilities to the dental nurse/receptionist. They explained that they set the practice up to increase patient choice and had a five year business plan to consolidate and develop the practice.

The practice had established a range of policies and procedures to help them manage the practice in line with legislation and national guidance. These included policies to support patient care and clinical governance, safety related matters and staffing issues. The policies had been compiled using relevant national guidance from the General Dental Council (GDC), British Dental Association (BDA) and the Care Quality Commission (CQC). Policies were dated and included original and review dates to maintain version control.

The practice had been open for one year when we inspected and the registered manager told us they were about to start a review of all of their policies. They had decided to adopt a new approach to these using a commercial package which linked policies and procedures to the operational tools needed to implement these in practice. They were aware they needed to tailor all of the new documents to the specific circumstances of the practice.

Although the practice had a number of policies relating to the safe management of patients' personal information they had not registered with the Information Commissioner as may be required.

We saw that the registered manager had the appropriate insurance in place and that their professional indemnity cover reflected the fact that this was a direct access dental hygienist service.

Leadership, openness and transparency

It was evident throughout our inspection and from comments from patients that the registered manager and dental nurse/receptionist communicated effectively and had a positive and professional working relationship. The atmosphere at the practice was efficient, relaxed and happy and this was also reflected in patients' comments.

Management lead through learning and improvement

The practice took training and development seriously and the dental nurse had received an annual appraisal for which they and had prepared using a structured template. They told us they completed a wide range of reading and courses for their continuous professional development (CPD) and showed us their well organised CPD evidence. They confirmed that the registered manager encouraged and supported them in this.

The practice had established a programme of clinical and other audits to help them monitor the care and treatment they provided. We saw that they had completed six monthly infection prevention and control audits, an access audit, an audit of patient surveys and suggestions and a patient record audit.

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

The practice used social media and in house survey forms to obtain patients views. They had issued a newsletter to patients on the anniversary of opening and had used this to say thank you to patients for their feedback. Whilst no patients had yet made suggestions for any improvements the newsletter emphasised that the practice wanted to continue to improve the service provided to patients. The practice had recently reviewed the patient survey forms for their first year. These showed that the 20 patients who had filled one in were happy with the practice and would recommend them to family and friends. No negative comments had been made but a suggestion was made to provide a raised chair for patients with restricted mobility. We saw that the practice had done this.

Although the team consisted of only two people, the registered manager and the dental nurse had held monthly staff meetings throughout the year they had been open. We saw minutes which showed that they had discussed a variety of topics including general administration, patient hospitality, sales of dental hygiene products, an update of practice policies, servicing arrangements for equipment, an oral health education initiative and planning for recruiting a second dental nurse/receptionist. In addition to structured monthly meetings they used frequent lunchtime discussions to help the smooth day to day running of the practice.