Wells Orthodontics Limited

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Inspection Report

11 Priory Road
Wells
BA5 1SU
Tel: 01749 675825
Website: www.wellsmile.co.uk/about-us

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Overall summary

We carried out an announced comprehensive inspection on 1 February 2017 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 this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Wells Orthodontics is situated in a Victorian semi-detached house converted to an orthodontic practice in 2007.The building is in the centre of Wells. It is easily accessed from the surrounding towns and villages with ample parking close by. The practice is fully accessible to disabled patients with dedicated disabled parking and a chair lift to the first floor where all facilities can be accessed on the same level.

The practice has five surgeries which are equipped with the orthodontic technology including a digital imaging centre to help patients achieve good oral health. The practice has a modern comfortable waiting area on the ground floor where patients can see the latest advances in orthodontic treatment on a TV screen.

The practice provides specialist orthodontic care for children and adults via the NHS and privately. Orthodontics is the branch of dentistry concerned with growth and development of orofacial structures, including irregularities of teeth, malocclusion, and associated facial problems.

The practice is open: Monday and Wednesday 8.30am-5.30pm, Tuesday and Thursday 8.30am-6.30pm, and Friday 8.30am–4.30pm.The practice is closed at the weekend.

The practice is registered with the Care Quality Commission (CQC) as a limited company and has a registered manager. Like registered providers, they are

Summary of findings

'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run. .

We received feedback from six patients about the service. The three CQC comment cards seen and six patients spoken with reflected very positive comments about the staff and the services provided. Patients commented the practice appeared clean and tidy and they found the staff very caring, friendly and professional. They had trust and confidence in the dental treatments and said explanations from staff were clear and understandable. They told us appointments usually ran on time and they would highly recommend the practice.

Our key findings were:

- There were systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control and responding to medical emergencies.
- We observed and were told by staff the practice ethos provided patient centred dental care in a relaxed and friendly environment.
- Leadership was provided by the principal specialist orthodontist dentist and an empowered practice manager.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available in accordance with current guidelines.
- The orthodontic practice had effective clinical governance and risk management processes in place; including health and safety and the management of medical emergencies.
- Patient care and treatment was delivered in line with evidence-based guidelines, best practice and current legislation including National Institute for Care Excellence (NICE) guidelines.
- Patient dental records were electronic, detailed and comprehensive.
- The practice had a comprehensive system to monitor and continually improve the quality of the service; including through a detailed programme of clinical and non-clinical audits.
- The use of digital radiographs to help explain necessary treatment to patients while in the chair.
- Premises appeared well maintained and visibly clean. Good cleaning and infection control systems were in place. The treatment rooms were well organised and equipped, with good light and ventilation.
- There were systems in place to check all equipment had been serviced regularly, including the air compressor, autoclave, fire extinguishers, oxygen cylinder and the X-ray equipment.
- There were sufficient numbers of suitably qualified staff who maintained the necessary skills and competence to support the needs of patients.
- Staff were up to date with current guidelines, supported in their professional development and the practice was led by a proactive principal dentist.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required with information for out of Hours service clearly available.
- Staff received training appropriate to their roles and were supported in their continuing professional development (CPD) by the company.
- Staff we spoke with felt well supported by the principal orthodontist and registered manager and were committed to providing a quality service to their patients.
- Specialist orthodontic dental care was provided in accordance with current legislation, standards and guidance.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation within their specialist field.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Patients were treated with dignity and respect and their confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The practice took into account any comments, concerns or complaints and used these to help them improve the service provided. We observed complaints were dealt with in a timely manner.

Summary of findings

- Common themes from the CQC comment cards were patients felt they received excellent care in a clean environment from a helpful practice team.
- Orthodontists, therapists and dental nurses all had specialist skills supported by enhanced skills training. They worked well as a team supporting each other and were able to undertake extended roles such as in radiography and taking impressions
- The practice had a dental/orthodontic laboratory on site for making and mending appliances which enabled a quick response to patient requirements.
- The role of a patient coordinator to ensure patients fully understood their treatment options.
- Patients had their treatment peer assessed and rated using the orthodontic peer assessment rating (PAR) index.

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

- Review the process for updating the Control of Substances Hazardous to Health (COSHH) file.
- Review the practice infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance with particular attention to the Annual Infection Control statement.
- Review the Legionella risk assessment and implement actions required including staff access to training about legionella awareness.

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

There were systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control and responding to medical emergencies. The practice carried out and reviewed risk assessments to identify and manage risks.

There were clear procedures regarding the maintenance of equipment and the storage of medicines in order to deliver care safely and in an emergency. In the event of an incident or accident occurring the practice documented, investigated and learnt from it.

Are services effective?

No action

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

The practice specialised in orthodontic treatment for straightening teeth. Patients received an assessment of their orthodontic and dental needs including recording and assessing their medical history. Explanations were given to patients in a way they understood and risks, benefits, options and costs were fully explained and patient consent taken. The practice kept detailed dental records of oral health assessments; treatment carried out and they monitored outcomes of treatment.

The treatment provided for patients was effective, evidence based and focussed on the needs of the individual. National Institute for Health and Care Excellence (NICE), British Orthodontic Society's guidance, Department of Health, national best practice and clinical guidelines were considered in the delivery of orthodontic care and treatment for patients.

Patients had their treatment peer assessed and rated using the orthodontic peer assessment rating (PAR) index. All orthodontists were trained in using the PAR index. (The PAR index is a robust way of assessing the standard of orthodontic treatment that an individual provider is achieving and determining the outcome of the orthodontic treatment in terms of improvement and standards). In orthodontics it is important to objectively assess whether a worthwhile improvement has been achieved in terms of overall alignment and occlusion for an individual patient for the greater proportion of a practitioner's caseload. This practice quality assured all their patients treatment using the PAR index

The staff were appropriately trained in delivering the specialised services they provided. Staff were registered with the General Dental Council and were meeting the requirements of their professional registration.

Are services caring?

No action

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

Summary of findings

We reviewed three completed CQC comments and received feedback from six patients about the care and treatment they received at the practice. The feedback was positive with patients commenting on the excellent service they received, professionalism and caring nature of the staff and ease of accessibility in an emergency. Patients commented they felt involved in their treatment and that it was fully explained to them.

The appointment system and record systems had a flagging system which highlighted to staff any patients special needs or medical conditions to enable them to treat patients individually and with care and understanding.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Policies and procedures in relation to data protection, security and confidentiality were in place and staff were aware of these.

Are services responsive to people's needs?

No action

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

The practice was aware of the needs of their patients and took these into account in how the practice was run. Patients had good access to appointments at the practice. There were good dental facilities in the practice and there was sufficient well maintained equipment to meet patients' needs.

Appointment times were convenient and met the needs of patients and they were seen promptly.

The practice was accessible once in the building and accommodated patients with a disability or lack of mobility. Treatment areas and a disabled accessible toilet were located on the first floor. Access to the first floor was via a stair lift. We observed the reception desk was compliant with the Equality Act 2010.

Information and forms were available in large print if needed. The practice had information materials available in a large font and access to translation services was available as needed. However there was no hearing loop system.

There was a procedure in place for acknowledging, recording, investigating and responding to complaints and concerns made by patients or their carers.

Are services well-led?

No action

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

The practice assessed risks to patients and staff and carried out a programme of audits as part of a system of continuous improvement and learning. There were clearly defined leadership roles within the practice and staff told us they felt well supported.

The practice had accessible and visible leadership with structured arrangements for sharing information across the team, including holding regular meetings which were documented for those staff unable to attend. Staff told us they felt well supported and could raise any concerns with the principal dentist or practice manager.

Summary of findings

The practice had systems in place to seek and act upon feedback from patients using the service.	

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Detailed findings

Background to this inspection

This inspection took place on 1 February 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider. We also reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and objectives, a record of any complaints received in the last 12 months and details of their staff members together with their qualifications and proof of registration with the appropriate professional body.

During the inspection we toured the premises and spoke with practice staff including four dentists (two specialist orthodontists, one dentist with a special interest in orthodontics; a dually qualified dental hygienist and orthodontic therapist; five dental nurses and two receptionists. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had systems in place to learn from and make improvements following any accidents or incidents. The practice had accident and significant event reporting policies which included information and guidance about the Reporting of Injuries and Dangerous Occurrences

Regulations 2013 (RIDDOR). Clear procedures were in place for reporting adverse drug reactions and medicines related adverse events and errors.

The practice maintained a significant event folder. Incidents had been appropriately documented and reported and treated according to the practice and national policy. We saw the documentation included a detailed description, the learning that had taken place and the actions taken by the practice as a result. Records seen showed accidents and significant events were discussed and learning shared at practice meetings.

The principal orthodontist and registered manager told us if there was an incident or accident that affected a patient; they would give an apology and inform them of any actions taken to prevent a recurrence. This was in accordance with the Duty of Candour principle. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

The principal orthodontist and registered manager knew when and how to notify CQC of incidents which cause harm. Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty.

The practice responded to national patient safety and medicines alerts that affected the dental profession. The principal orthodontist told us they reviewed all alerts and spoke with staff to ensure they were acted upon. A record of the alerts was maintained and accessible to staff.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team, social services and other agencies including the Care Quality Commission. Staff had completed safeguarding training and demonstrated to us, when asked, their knowledge of how to recognise the signs and symptoms of abuse and neglect. There was a documented reporting process available for staff to use if anyone made a disclosure to them.

Staff demonstrated knowledge of the whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.

During the inspection we observed the orthodontic care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. Orthodontic care records were paper and electronic and contained a medical history that was obtained and updated prior to the commencement of orthodontic treatment and at regular intervals of care. The dental care records seen were well-structured and contained sufficient detail to demonstrate what treatment had been prescribed or completed, what was due to be carried out next and details of possible alternatives.

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments). The practice was not using dental safety syringes which had a needle guard in place to support staff use and to dispose of needles safely in accordance with the European Union Directive; Health and Safety (Sharps Instruments in Healthcare) Regulations 2013. However when this was pointed out to the provider they ordered the dental safety syringes and showed us the evidence to confirm they had taken action.

Staff files contained evidence of immunisation against Hepatitis B (a virus contracted through bodily fluids such as; blood and saliva) and there were adequate supplies of personal protective equipment such as face visors, gloves and aprons to ensure the safety of patients and staff.

Medical emergencies

The practice had suitable emergency resuscitation equipment in accordance with guidance issued by the Resuscitation Council UK. This included an automated

Are services safe?

external defibrillator (AED). (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to medical oxygen along with other related items such as manual breathing aids in line with the Resuscitation Council UK guidelines. The emergency medicines and equipment were stored in a central location, clearly labelled and known to all staff.

Staff spoken with showed us documentary evidence which demonstrated regular checks were done to ensure the equipment and emergency medicines were in date and safe to use. Records showed all staff had completed on site training in emergency resuscitation and basic life support. Staff spoken with demonstrated they knew how to respond in the event of a medical emergency. We saw two members of staff had completed First Aid at work training. The first aid kit was checked and recorded at the same time as the emergency medicines.

Staff recruitment

The practice had systems in place for the safe recruitment of staff which included seeking references, proof of identity and checking qualifications, immunisation status and professional registration. It was the practice policy to carry out Disclosure and Barring service (DBS) checks for all newly appointed staff. These checks 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. Records confirmed these checks were in place. We looked at the recruitment files for three members of staff and found they contained appropriate recruitment documentation.

Newly employed staff had an induction period to familiarise themselves with the way the practice ran before being allowed to work unsupervised. Newly employed staff met with the practice manager and principal dentist to ensure they felt supported to carry out their role.

The practice had a system in place for monitoring staff had up to date medical indemnity insurance and professional registration with the General Dental Council (GDC) The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. Records we looked at confirmed these were up to date.

There were sufficient numbers of suitably qualified and skilled staff working at the practice. A system was in place to ensure that when absences occurred they would cover for their colleagues.

Monitoring health & safety and responding to risks

The practice had systems to monitor health and safety and deal with foreseeable emergencies. There were comprehensive health and safety policies and procedures in place to support staff, including for the risk of fire and patient safety. Records showed that fire detection and firefighting equipment such as the fire alarm, smoke detectors and fire extinguishers were regularly tested.

The practice had a comprehensive risk management process, including a detailed log of all risks identified, to ensure the safety of patients and staff members. For example, we saw a fire risk assessment and a practice risk assessment had been completed. They identified significant hazards and the controls or actions taken to manage the risks. The practice manager told us the risk assessments would be reviewed annually.

The practice had a comprehensive file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, blood and saliva. We observed the COSHH file appeared not to have been updated for some time. The practice manager and principal orthodontist assured us a protocol would be put in place immediately to ensure this was done.

The practice had a detailed business continuity plan to support staff to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The plan included staffing, electronic systems and environmental events.

We saw records which demonstrated that fire detection and firefighting equipment such as fire alarms and fire extinguishers were regularly tested. A recent fire drill had been carried out and the outcome documented. Fire drills took place every six months.

Infection control

Are services safe?

There were effective systems in place to reduce the risk and spread of infection. There was a written infection control policy which included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments, hand hygiene, segregation and disposal of clinical waste.

The practice had followed the guidance about decontamination and infection control issued by the Department of Health, the 'Health Technical Memorandum 01-05 decontamination in primary care dental practices (HTM01-05)' and complied with the requirements of the DOH publication 'Code of Practice' July 2015. These documents and the practice policy and procedures for infection prevention and control were accessible to staff. We were shown the recent audits of infection control processes carried out in 2016 which confirmed compliance with HTM 01-05 guidelines.

However there was not an annual statement in relation to infection prevention control as required under The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance. In discussion n with the principal dentist they told us they were unaware of the need for a statement and would take action immediately to complete one.

There was a dedicated decontamination room in the practice which was used for cleaning, sterilising and packing instruments. There was clear separation of clean and dirty areas in the treatment room and the decontamination room with signage to reinforce this. These arrangements met the HTM01- 05 essential requirements for decontamination in dental practices.

We observed the decontamination process and noted suitable containers were used to transport dirty and clean instruments between the treatment rooms and decontamination room. The practice used a washer disinfector for the initial cleaning process, then following inspection with an illuminated magnifier the instruments were then placed into an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.

We were shown the systems in place to ensure the autoclaves used in the decontamination process were working effectively. It was observed the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date. All recommended tests utilised as part of the validation of the washer disinfector were carried out in accordance with current guidelines thus ensuring safe decontamination of the dental instruments. The results for the above were recorded in an appropriate log file.

We observed how waste items were disposed of and stored securely until collection. The practice had an on-going contract with a clinical waste contractor. We saw the differing types of waste were appropriately segregated.

Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of according to the guidance.

We looked at the consultation and treatment rooms where patients were examined and treated and observed the rooms and all equipment appeared clean, uncluttered and well-lit with good ventilation. Staff told us the importance of good hand hygiene was included in their infection control training. A hand washing poster was displayed near the sink to ensure effective decontamination. There were good supplies of protective equipment for patients and staff members. The practice uses latex free disposable gloves for the protection of patients and staff.

We reviewed the last detailed legionella risk assessment report from 2017 which was carried out by an external organisation. The principal orthodontist told us they had not yet implemented the actions required in the assessment but assured they would implement these without delay particularly the monthly testing of the hot and cold sentinel taps in the practice as required by the HSE publication ACOP L8. However there were other processes in place to prevent legionella contamination such as flushing of dental unit water lines with an appropriate disinfectant.

The above processes ensured the risks of Legionella bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise risk of patients and staff developing Legionnaires' disease. (Legionella is a bacterium found in all potable water and which if not controlled can put staff and patients at risk of contracting Legionnaires disease which can be fatal.)

There was a good supply of cleaning equipment which was colour coded and stored appropriately. It followed

Are services safe?

published National Patient Safety Association (NPSA) guidance about the cleaning of dental primary care premises. The practice had a cleaning schedule in place that covered all areas of the premises and detailed what and where equipment should be used.

The practice had a process for staff to follow if they accidentally injured themselves with a needle or other sharp instrument. The practice manager had a system for monitoring the immunisation status of each member of staff for the safety and protection of patients and staff.

Equipment and medicines

There were systems in place to check all equipment had been serviced regularly, including the compressor, autoclaves, X-ray equipment and fire extinguishers. Records showed contracts were in place to ensure annual servicing and routine maintenance work occurred in a timely manner. A portable appliance test (PAT – this shows electrical appliances are routinely checked for safety) had been carried out annually by an appropriately qualified person to ensure the equipment was safe to use.

The practice had policies and procedures regarding the prescribing, recording, use and stock control of the medicines used in clinical practice. The batch numbers and expiry dates for local anaesthetics were recorded in patients' dental care records.

Prescriptions pads were stored securely and details were recorded in patients' dental care records of all prescriptions issued.

We observed the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and spillage.

Radiography (X-rays)

X-ray equipment was used and X-rays were carried out safely and in line with local rules that were relevant to the practice and equipment and in line with published guidance from the British Orthodontic Society (BOS). We observed local rules were displayed in areas where X-rays were carried out.

We were shown a well maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). It was detailed and up to date with an inventory of all X-ray equipment and maintenance records**.** X-rays were digital and images were stored within the patient's dental care record.

The names of the Radiation Protection Advisor and the Radiation Protection Supervisor were clearly identified. The file included the critical examination packs for the X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

The dental care records we saw showed dental X-rays were justified, quality assured (graded) and reported upon every time. X-rays were taken in line with current guidelines by the Faculty of General Dental Practice of the Royal College of Surgeons of England and national radiological guidelines.

These findings showed the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. The dentists monitored the quality of the X-ray images regularly and records of these x-ray audits were maintained.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The clinical staff were familiar with, and used current professional guidance for dentistry, and specifically orthodontics. The British Orthodontic Society's (BOS) guidelines were used routinely in care and treatment of their patients.

Patients attending the practice for consultation and treatment received an assessment of their dental conditions and needs which began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence, and were told by patients, the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues to assess their oral health and treatment needs.

Clinical assessment of children involved using the Index of Treatment Need (IOTN). The IOTN is used to assess the need and eligibility of children under 18 years of age for NHS orthodontic treatment on dental health grounds. The British Orthodontic Society believes that the IOTN is an objective and reliable way to select those children who will benefit most from treatment and is a fair way to prioritise NHS resources. The accurate use of IOTN requires specialist training and the assessment of dental health need for orthodontics using the IOTN should take place in a specialist orthodontic practice. The dentists, therapists and dental nurses at the practice were all trained in this specialty.

Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail. Different types of braces were used to straighten teeth and details of the treatment provided were documented .We observed a patient with the treatment coordinator whose role was to ensure patients fully understood treatment options and costings, if relevant.

The staff we spoke with and evidence we reviewed confirmed care and treatment was aimed at ensuring each patient was given support to achieve the best outcomes for them. We found from our discussions staff completed assessments and treatment plans in line with The National Institute for Health and Care Excellence (NICE) and national BOS guidelines. These plans were reviewed appropriately.

It was confirmed by dentists and patients we spoke with that each patient's treatment needs was discussed with them and treatment options were explained. Preventative dental and oral health advice and information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures.

The clinical staff we observed were supported by a hygienist whose role was to help patients maintain and improve their oral health. The patient's notes were updated with the proposed treatment after discussing options with them. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

The practice undertook a number of quality monitoring audits regularly. These included radiographs, treatment planning, medical history taking and record keeping. Patients had their treatment peer assessed and rated using the peer assessment rating (PAR) index.

The orthodontists were trained in the use of the PAR index. (The PAR index is a robust way of assessing the standard of orthodontic treatment an individual provider is achieving and determining the outcome of the orthodontic treatment in terms of improvement and standards). In orthodontics it is important to objectively assess whether a worthwhile improvement has been achieved in terms of overall alignment and occlusion for an individual patient or the greater proportion of a practitioner's caseload. This practice quality assured their patients treatment using the PAR index in line with NHS contractual requirements.

We reviewed three CQC comment cards and spoke with six patients on the day of inspection. Feedback we received reflected patients were very satisfied with the assessments, explanations and the quality of the treatment.

Health promotion & prevention

Oral health promotion was part of the practice philosophy. To facilitate good orthodontic treatment oral hygiene was an important factor. The orthodontists, therapists and dental nurses all provided oral health advice and education tailored to patients' individual needs.

The waiting room and reception area at the practice contained literature that explained the services offered at the practice in addition to information about effective

Are services effective?

(for example, treatment is effective)

dental hygiene and how to reduce the risk of poor dental health. We observed the staff giving patients good quality information leaflets and explaining the information to them.

Adults and children attending the practice were educated in oral health and how to maintain good oral hygiene during the course of their treatment. Tooth brushing techniques were explained to them in a way they understood, smoking and alcohol advice (for adults) was also given to them.

This was in line with guidance issued in the Public Health England publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting and to improve oral health. The sample of dental care records we observed demonstrated dentists had given oral health advice to patients. Oral Health products such as tooth brushes, inter dental cleaning aids and mouthwash were for sale and available at the reception desk.

Staffing

The practice had three specialist orthodontists, one orthodontic therapist, one dental hygienist/orthodontic therapist, five qualified dental nurses, a dental laboratory technician, a receptionist, treatment coordinator and a practice manager and assistant manager. Dental staff were appropriately trained and registered with their professional body.

The orthodontists, therapists and dental nurses were appropriately qualified and the orthodontists and therapists were listed on the specialist orthodontics register of the GDC. Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels and had access to various role related courses both online and face to face. CPD is a compulsory requirement of registration as a general dental professional and this activity contributes to their professional development.

The practice manager planned ahead to ensure there were sufficient staff to run the service safely and meet patient needs.

The registered manager kept a record of all training completed by staff to ensure they had the right skills to carry out their work. Mandatory training included basic life support, hand hygiene, fire safety and infection prevention and control had been completed by all staff within the last 12 months. New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. Dental nurses received day to day supervision from the orthodontists and support from the lead nurse and registered manager.

Staff had access to policies which contained information that further supported them in the workplace. All clinical staff were required to maintain an on-going programme of continuing professional development as part of their registration with the General Dental Council. Records showed professional registration was up to date for all staff.

There was an effective appraisal system in place which was used to identify training and development needs. Staff we spoke with told us they had accessed specific training in the last six months in line with their professional needs. They told us the practice was supportive and someone was always available for advice and guidance. We saw the dental nurses were supported to undertake further training relevant to their role such as radiography and impression taking.

Working with other services

The practice manager explained how they worked with other services. As a specialist treatment centre they took referrals for treatment from across the area. They were also able to refer to other services as needed and liaised with the patient's general dental practitioner regarding their care and treatment.

The dentists were also involved in the local orthodontic peer review group where good practice and ideas within the speciality were shared.

Consent to care and treatment

Staff explained to us how valid consent was obtained for all care and treatment. The practice consent policy provided staff with guidance and information about when consent was required and how it should be recorded.

Staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and their responsibilities to ensure patients had enough information and the capacity to consent

Are services effective?

(for example, treatment is effective)

to orthodontic treatment. Staff explained how they would consider the best interests of the patient and involve family members or other healthcare professionals responsible for their care to ensure their needs were met.

Staff had undertaken specific MCA training and when asked they demonstrated a good working knowledge of its application in practice. All staff understood consent could be withdrawn by a patient at any time.

The staff we spoke with were also aware of and understood the use of the Gillick competency test in relation to young persons (under the age of 16 years). The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

We reviewed dental care records to corroborate our information. Treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. Consent to treatment was recorded. Feedback in CQC comment cards and from patients spoken with confirmed patients were provided with sufficient information to make decisions about the treatment they received.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We reviewed three completed CQC comments cards and spoke with six patients during the inspection. Comments from patients were consistently positive about how they were treated by staff at the practice. Patients commented they were treated with respect and dignity and that staff were friendly and reassuring. We observed positive interactions between staff and patients during the inspection.

We observed staff at the practice treated patients with dignity and respect and maintained their privacy and confidentiality. There was also the treatment coordinators room where patients and parents/carers could discuss treatment issues in private. Staff were clear about the importance of emotional support needed when delivering care to patients who were very nervous or fearful of dental treatment. This was supported by patients' comments we reviewed which told us they were well cared for when they were nervous or anxious and this helped make the experience better for them.

The principal dentist told us they would act upon any concerns raised by patients regarding their experience of attending the practice.

To maintain confidentiality electronic dental care records were password protected and paper records were securely stored. The design of the reception desk ensured any paperwork and the computer screen could not be viewed by patients booking in for their appointment. Policies and procedures in relation to data protection, security and confidentiality were in place and staff were aware of these.

All treatment room doors remained closed during consultations to maintain patient privacy and confidentiality.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt fully involved in making decisions about their treatment, were at ease speaking with the dentists and felt listened to and respected. Staff described to us how they involved patient's relatives or carers when required and ensured there was sufficient time to explain fully the treatment options. Dental care records we looked at corroborated and reflected this. Staff explained they made it clear that a patient could withdraw consent at any time.

Patients were given a copy of their treatment plan and associated costs. This gave patients clear information about the different elements of their treatment and the costs relating to them. They were given time to consider options before returning to have their treatment. Patients signed their treatment plan before treatment began. The treatment coordinator was available to offer time for further consultation and advice during the decision making process.

Patients' comments told us the staff were professional and care and treatments were always explained in a language they could understand. Information both written and verbal was given to patients enabling them to make informed decisions about care and treatment options.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice information leaflet, information displayed on the website and in the waiting area described the range of services offered to patients and included information in relation to the complaint procedure. The practice provided mostly NHS treatment and some private care. Treatment costs, where appropriate, were clearly displayed.

Each patient contact was recorded in the patient's dental care record. New patients completed a medical history and dental questionnaire. This enabled the practice to gather important information about their previous dental, medical and relevant social/lifestyles history.

Staff aimed to capture the patient's expectations in relation to their needs and concerns which helped direct them to provide the most effective form of treatment. We observed the patient coordinator played a vital role in this process. Staff were alerted if a patient had special needs or medical conditions through a flagging system on the computer which helped them treat patients individually and with care and understanding.

Patients' feedback demonstrated they had flexibility and choice to arrange appointments in line with other commitments. Patients booked in with the receptionist on arrival and they kept patients informed if there were any delays to appointment times.

Patients we talked with advised they had been able to obtain emergency treatment when needed

Tackling inequity and promoting equality

The practice had a comprehensive equality, diversity and human rights policy in place and provided training to support staff in understanding and meeting the needs of patients.

The practice had a short flight of steps from ground level to the first floor with a chair lift available to enable access for patients with a disability or mobility difficulties. Once in the practice all facilities and was accessible to patients as treatment areas and an accessible toilet were located on the ground floor with a flat floor access to this area.

They did not have a hearing loop at reception; however large print leaflets and forms were available if required. Access to translation services was available when required.

Access to the service

Appointment times and availability met the needs of patients. The arrangements for obtaining emergency dental advice outside of normal working hours were detailed in the reception area, in the information leaflet and on the website. We observed space was left daily in the appointment book for emergencies and patients we spoke with advised they had been able to seek emergency care in a timely manner.

The three CQC comment cards and six patients we spoke with and comments we received told us there were no concerns regarding waiting times and that appointments usually ran on time. Patients commented they had sufficient time during their appointment for discussions about their care and treatment and for planned treatments to take place. They told us they had good access to the service and appointments were flexible to meet their needs.

Concerns & complaints

The practice had a complaint policy which provided staff with clear guidance about how to handle a complaint. The policy explained the process to follow, and included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included the Dental Complaints Service. Staff told us if they raised any formal or informal comments or concerns with the principal dentist they ensured these were responded to appropriately and in a timely manner.

The practice had received one complaint in the last 12 months. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.

We found there was a system in place which ensured a timely response, sought to address the concerns promptly and efficiently and effect a satisfactory outcome for the patient. The registered manager showed us that any complaints made were investigated and the outcome discussed amongst the team and implemented for the safety and well-being of patients.

Are services well-led?

Our findings

Governance arrangements

The practice had robust governance arrangements in place for monitoring and improving the services provided for patients. Staff we spoke with were aware of their roles and responsibilities within the practice. Staff had lead roles for example in decontamination, infection control and safeguarding. Some clinical staff indicated they had received advanced training for example some nurses were able to take impressions or radiographs.

The practice carried out regular audit cycles. These included for example, treatment planning, medical history taking, radiographs and record keeping. Audits were completed regularly and re audits were evident, which demonstrated improved outcomes. Treatment outcomes were peer assessed and rated using the peer assessment rating (PAR) index. The orthodontists were all trained in the use of the PAR index. The practice quality assured their patients treatment using the PAR index which demonstrated good practice.

Health and safety and risk management policies were in place including processes to ensure the safety of patients and staff members. We looked in detail at how the practice identified, assessed and managed clinical and environmental risks related to the service provided. We saw risk assessments and the control measures in place to manage those risks for example fire, use of equipment and infection control. Lead roles, for example in infection control and safeguarding supported the practice to identify and manage risks and helped ensure information was shared with all team members.

There were relevant policies and procedures in place to govern activity. There was a full range of policies and procedures in use at the practice and accessible to staff on the practice computers and in paper files. Staff were aware of the policies and procedures and acted in line with them.

These included guidance about confidentiality, record keeping, inoculation injuries and patient safety. There was a clear process in place to ensure all policies and procedures were reviewed as required to support the safe running of the service. There were monthly practice meetings to discuss practice arrangements and audit results as well as providing time for educational activity.

We saw minutes from meetings where issues such as complaints, incidents, infection control and patient care had been discussed and a training topic had been covered. Minutes demonstrated staff meetings were held at a time when most staff could attend. For staff who were unable to attend the meetings there was a system in place to ensure meeting information was shared with them.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty. The ethos of the practice detailed they were committed to putting patients' needs first and making every patient feel comfortable, assured and confident.

Staff were aware of who to raise any issues with and told us the dentists, practice manager and other staff listened to their concerns and acted appropriately. They told us there were clear lines of responsibility and accountability within the practice and that they were encouraged to report any safety concerns. We were told there was a no blame culture at the practice and the delivery of high quality care was part of the practice ethos.

The practice had a statement of purpose. Staff could articulate the values and ethos of the practice to provide high quality dental care and put the patient first.

Learning and improvement

The practice had an established structured plan in place to audit quality and safety beyond the mandatory audits for infection control and radiography.

Staff told us the practice supported them to maintain and develop through training, and mentoring. Regular appraisal and development reviews took place and individual personal development plans developed were meaningful to support staff.

The practice staff attended training days and sessions. These included basic life support and safeguarding. Online training was accessible to staff for their continuing professional development.

The clinical staff kept themselves up to date with current best practice guidelines for dentistry and in particular orthodontics and were involved in local peer review. Clinical staff had received enhanced training in orthodontics. The dental professionals were registered with the General Dental Council (GDC). The GDC registers all dental care professionals to make sure they are

Are services well-led?

appropriately qualified and competent to work in the UK. Staff were encouraged and supported to maintain their continuing professional development as required by the GDC.

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

The practice had systems in place to seek and act upon feedback from patients using the service. The practice gathered feedback from patients through their own internal systems which were analysed every month and the results displayed. They also had a compliments book and complaints system for feedback.

The practice staff told us patients could give feedback at any time they visited. Results of the most recent patient satisfaction review indicated that 98% of patients who completed the survey were happy with the quality of care provided by the practice and patients were likely to recommend the practice to family and friends.

The practice also gathered feedback from patients through the NHS Friends and Family Test (FFT), NHS Choices, compliments and complaints. Results of the most recent Family and Friends Test (FFT) indicated that 98% of patients who completed the survey were happy with the quality of care provided by the practice and patients were either highly likely or likely to recommend the practice to family and friends

The practice regularly asked for patient feedback at the end of treatment and the results seen corroborated the comments received from patients we spoke with and as seen on the CQC comment cards.

The practice held regular monthly documented meetings at which clinical and practice management issues could be discussed. Staff told us they received important information and feedback through these meetings.