Smile Stylist Ltd

Smilestylist - House of Fraser Birmingham

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 16 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

Smilestylist House of Fraser Birmingham Dental Practice has two dentists who work part time, one qualified dental nurse who is registered with the General Dental Council (GDC) a practice manager and a receptionist. The practice's opening hours are 9.30am to 6pm on Monday, Tuesday, Wednesday and Friday, and 10.30am to 7pm Thursday. The practice is also open every Saturday from 9am to 5.30pm. The practice is closed for 30 minutes each day between 2.30pm to 3pm.

Smilestylist Dental Practice provides private dental treatment for adults and children. The practice is located within the House of Fraser department store. There are a few small steps within the store to gain access to the dental practice. There are two dental treatment rooms one of which is used for the specific purpose of tooth whitening. There is a separate decontamination room for cleaning, sterilising and packing dental instruments and a consultation room. There is also a reception and waiting area.

Summary of findings

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

Before the inspection we sent Care Quality Commission comments cards to the practice for patients to complete to tell us about their experience of the practice and during the inspection we spoke with patients. We received feedback from seven patients who provided an overwhelmingly positive view of the services the practice provides. All of the patients commented that the quality of care was very good and that staff were friendly and helpful.

Our key findings were

- Systems were in place for the recording and learning from significant events and accidents.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients were treated with dignity and respect.
- The practice was visibly clean and well maintained.
- Infection control procedures were in place with infection prevention and control audits being undertaken on a six monthly basis. Staff had access to personal protective equipment such as gloves and aprons.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. Systems were in place to check these to ensure that they were within their expiry dates; however checks were not completed regularly as recommended by national guidance.
- Staff had been trained to deal with medical emergencies.
- The practice was well-led and staff felt involved and worked as a team.

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review the timescales for the checking and documentation of checks regarding medicines to manage medical emergencies giving due regarding to the guidelines issued by the Resuscitation Council (UK).
- Review systems in place for the recording of medicines dispensed at the practice to ensure documentation kept is signed by the prescriber.
- Review the systems in place for scheduling of appointment times to ensure that patients are given times of appropriate length for the treatment to be completed.
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- Review the practice's audit protocols of various aspects of the service, such as radiography and dental care records to help improve the quality of service. Review its audit protocols to document learning points that are shared with all relevant staff and ensure that the resulting improvements can be demonstrated as part of the audit process.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

Systems were in place for recording significant events and accidents. Staff were aware of the procedure to follow to report incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Medicines for use in an emergency were available on the premises as detailed in the Guidance on Emergency Medicines set out in the British National Formulary (BNF). Emergency medical equipment was also available and documentation was available to demonstrate that checks were being made to ensure equipment was in good working order and medicines were within their expiry date. However these checks were not being completed on a weekly basis in accordance with the timescales set by the Resuscitation Council (UK) guidance. Staff had received training in responding to a medical emergency.

Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Infection control audits were being undertaken on a six monthly basis. The practice had systems in place for waste disposal and on the day of inspection the practice was visibly clean and clutter free.

Are services effective?

No action

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

Dental care records did not demonstrate that the dental care provided was evidence based and focussed on the needs of the patients. There was no documentary evidence to demonstrate that the practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

There was no evidence in the dental care records we were shown that the practice used screening tools to identify oral disease. Patients and staff told us that explanations about treatment options and oral health were given to patients in a way they understood and risks, benefits, options and costs were explained. However the practice was not able to evidence that they were following recognised professional guidelines. Following this inspection we received confirmation from the registered manager that dentists had been booked on to a record keeping course. Staff had been given detailed guidance regarding the information which would now be included in patient records.

Staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

No action

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

Summary of findings

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Staff treated patients with kindness and respect and were aware of the importance of confidentiality. Feedback from patients was positive stating that they had very good experiences of dental care provided at the practice. Patients commented that staff were professional, friendly and helpful.

Are services responsive to people's needs?

No action 

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

The practice was aware of the needs of the local population and considered these in how the practice was run.

Patients could access routine treatment and urgent or emergency care when required. The practice offered dedicated emergency appointments each day enabling effective and efficient treatment of patients with dental pain.

The practice had developed a complaints' procedure and information about how to make a complaint was available for patients to reference.

Are services well-led?

No action 

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

There was an effective management structure in place. Regular staff meetings were held and systems were in place to ensure all staff who were unable to attend the meeting received an update about topics of discussion. Staff said that they felt well supported and could raise any issues or concerns with the registered manager.

Annual appraisal meetings took place and staff said that they were encouraged to undertake training to maintain their professional development skills. Staff told us the provider was very approachable and supportive and the culture within the practice was open and transparent. Staff told us they enjoyed working at the practice and felt part of a team.

Smilestylist - House of Fraser Birmingham

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.

This inspection took place on 16 August 2016 and was led by a CQC inspector and supported by a specialist dental advisor. Prior to the inspection, we reviewed information we held about the provider. We asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During our inspection we toured the premises; we reviewed policy documents and staff recruitment records and spoke with four members of staff, including the registered manager. We looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the dental care records.

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.

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There had been no patient or staff accidents since the practice opened. There was an accident reporting policy in place to guide staff of the process to follow to report accidents. We saw that accident reporting books and significant event reporting forms were available.

All staff we spoke with understood the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR). Staff told us that they were able to access reporting forms via the internet to report incidents under RIDDOR regulations if necessary. We also saw that forms and guidance was available for staff in a separate file. We were told that there had been no events at the practice that required reporting under RIDDOR. We found that systems were in place to enable staff to report incidents and accidents.

We discussed significant events with the registered manager. We were told that the practice did not have any significant events to report. The registered manager was the significant events lead and staff spoken with were aware who held this role.

Systems were in place to ensure that all staff members were kept up to date with any national patient safety and medicines alerts. The registered manager received these alerts via email and any that were relevant were forwarded to all staff at the practice; copies were kept on the computer system.

We saw that an overview of Duty of Candour was available for staff. This informed staff that the practice would inform patients when things went wrong, when there was an incident or accident and patients would be given an apology.

Reliable safety systems and processes (including safeguarding)

The practice had developed a safeguarding file which contained relevant information for staff. Policies were available regarding child protection and safeguarding vulnerable adults. These policies were implemented in January 2016. Staff had signed a document to say that they had read and understood this policy. However we saw that some of these staff no longer worked at the practice and some of the newly employed staff had not signed this document.

The practice also had a 'child protection policy statement of intent' which was developed in May 2013 and had been reviewed in November 2015. Information for staff regarding the Care Quality Commission's (CQC) roles and responsibilities for safeguarding were available. Details of how to report suspected abuse to the local organisations responsible for investigation were available.

One of the dentists who worked at the practice had been identified as lead regarding child protection; the registered manager was documented as lead and the dentist as deputy lead regarding safeguarding vulnerable adults. All staff spoken with were aware of who they should speak to for advice or to report suspicions of abuse.

We saw that one of the dentists had completed a presentation to staff regarding safeguarding. The presentation was available in the safeguarding file for staff to refresh their memory if required. We were told that the information was presented to staff in October 2015.

We were told that there had been no safeguarding issues to report. We saw evidence that staff had completed the appropriate level of safeguarding training.

The practice used a system whereby needles were not re-sheathed using the hands following administration of a local anaesthetic to a patient. A special device was used during the recapping stage and the responsibility for this process rested with each dentist. We were told that there had been no sharps injuries at the practice. A sharps injury risk assessment had been completed.

We asked about the instruments which were used during root canal treatment. The registered manager explained that these instruments were single use only. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured. We could not find any evidence in patient's notes to demonstrate that root canal treatment was carried out where practically possible using a rubber dam.

No action

Are services safe?

Medical emergencies

There were systems in place to manage medical emergencies at the practice. Emergency equipment including oxygen and 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), was available. We saw that the oxygen and AED were checked on a daily basis to ensure they were in good working order. The practice had a policy regarding emergency equipment which recorded that a spare emergency oxygen cylinder should be available at the practice which is over and above national guidance; this additional cylinder was not available on the day we inspected.

We saw that a log of emergency medical equipment was available which recorded expiry dates. Staff checked this equipment on a monthly basis. Staff were only recording the month that the equipment was checked and not the specific date.

Emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. All emergency medicines were appropriately stored and staff spoken with were aware of their location. Emergency medicines were checked on a monthly basis to ensure they were within date for safe use. The resuscitation council guidelines state that emergency medicines and medical equipment should be checked on at least a weekly basis.

Staff had all received annual training in basic life support in March 2016.

We saw that a first aid kit was available which contained equipment for use in treating minor injuries. Detailed information was available for staff regarding the equipment in the first aid box and how and when to use it. We saw that the practice had completed a first aid and emergency audit checklist in October 2015. This questioned, for example, staff knowledge of the location of the first aid kit and audited whether there was a record of the oxygen cylinder usage.

The practice manager and registered manager had both undertaken first aid training and were the designated first aiders at the practice.

Staff recruitment

We discussed the recruitment of staff and looked at one recruitment file in order to check that recruitment procedures had been followed. We saw that this file contained pre-employment information such as proof of identity, written references details of qualifications and registration with professional bodies. Staff had also completed a pre-employment medical questionnaire.

Recruitment files also contained other information such as contracts of employment, job descriptions, and copies of policies and procedures such as grievance, hand hygiene and health and safety. Staff were given copies of policies, training books and leaflets upon employment at the practice.

We saw that Disclosure and Barring Service checks (DBS) were in place and we were told that these had been completed for all staff. DBS 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.

The practice planned for staff absences to ensure the service was uninterrupted. We were told that staff had to book their annual leave in advance to enable staff from other practices within the group to be made available to provide cover. These staff would also be requested to provide cover at times of unexpected sick leave.

There were enough staff to support dentists during patient treatment. We were told that all dentists and the dental hygienist worked with a dental nurse.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. A health and safety poster was on display in the decontamination room and a health and safety policy had been developed which had been reviewed on an annual basis.

Numerous risk assessments had been completed, for example decontamination, display screen equipment, electrical equipment, first aid, immunisation, expectant mothers and a general practice risk assessment. Risk assessments were reviewed on an annual basis.

The registered manager was the named lead regarding health and safety. All staff spoken with said that they could speak with the registered manager or practice manager for health and safety advice if required.

No action

Are services safe?

We discussed fire safety with staff and looked at the practice's fire safety risk assessment and associated documentation. We saw that a fire risk self-assessment had been completed by the registered manager in July 2015. This had been reviewed in July 2016 and no issues for action were identified. We were told that the department store also completed a detailed fire risk assessment which included the dental practice. Other fire safety checks including fire alarm, smoke detectors, emergency lighting and checking fire exits was completed by staff at the department store.

We discussed fire drills with the registered manager. We were shown documentary evidence to demonstrate that two fire drills were held per year which incorporated all staff within the department store. In addition to this the dental practice also completed a monthly fire drill and records were kept to confirm this.

Detailed information had been produced regarding location of fire exits and photographs and written information gave staff details regarding fire procedures within the department store. We saw a copy of the fire evacuation plan dated July 2015 which had been reviewed in July 2016.

Standardised documentation for personal emergency evacuation plans were available, these would be amended as necessary to meet the needs of staff employed at the dental practice.

We saw records which confirmed that fire safety equipment such as fire extinguishers were subject to routine maintenance by external professionals.

A well organised Control of Substances Hazardous to Health (COSHH) file was available which recorded details of all substances used at the practice which may pose a risk to health.

Infection control

As part of our inspection we conducted a tour of the practice. We saw that the dental treatment rooms, waiting areas, reception were visibly clean, tidy and uncluttered.

Staff who worked at the practice were responsible for undertaking all environmental cleaning of both clinical and non-clinical areas. The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises and signage was in place to identify which colour of cleaning equipment was specific for use in that area.

Systems were in place to reduce the risk and spread of infection within the practice. There were hand washing facilities in each treatment room and in the decontamination room.

Staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. Staff uniforms ensured that staff member's arms were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers.

Infection prevention and control audits were completed on a six monthly basis. No issues for action were identified in recent audits completed.

We looked at the procedures in place for the decontamination of used dental instruments. A separate decontamination room was available for instrument processing.

The decontamination room had dirty and clean zones in operation to reduce the risk of cross contamination and these were clearly identified.

A dental nurse demonstrated the decontamination process and we found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). Systems were in place to ensure that instruments were safely transported between treatment rooms and the decontamination room.

The dental nurse showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. The practice was using an ultrasonic bath. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and a liquid. After the ultrasonic bath Instruments were rinsed and then a visual inspection was undertaken using an illuminated magnifying glass before instruments were sterilised in an autoclave. There was a clear flow of instruments through the dirty to the clean area. Staff wore personal protective equipment during the

process to protect themselves from injury which included gloves, aprons and protective eye wear. Clean instruments were packaged; date stamped and stored in accordance with current HTM 01-05 guidelines.

All the equipment used in the decontamination process had been regularly serviced and maintained in accordance with the manufacturer's instructions and records were available to demonstrate this equipment was functioning correctly.

The dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria, legionella is a term for particular bacteria which can contaminate water systems in buildings. A risk assessment regarding Legionella had been carried out by an external agency and up to date water quality certificates were seen.

We discussed clinical waste with the practice manager; we looked at waste transfer notices and the storage area for clinical and municipal waste. We were told that clinical waste was collected every few weeks. Clinical waste storage was in an area where members of the public could not access it.

Sharps bins were fixed to walls in appropriate locations which were out of the reach of children.

The practice had conducted a needle stick injury assessment; this was an internal audit on the potential causes for needle stick injuries.

Equipment and medicines

We saw that maintenance contracts were in place for essential equipment such as X-ray sets, compressors and autoclaves. Records demonstrated the dates on which the equipment had recently been serviced.

All portable electrical appliances at the practice had received an annual visual portable appliance test (PAT) by the practice manager on 21 June 2016. A more detailed PAT test was organised by the department store to include all electrical equipment throughout the store on 27 July 2016. Electrical equipment tested was listed with details of whether the equipment had passed or failed the test.

We saw that an electrical installation condition report had been completed on 31 July 2016 which had identified work to be undertaken. The registered manager confirmed that they had requested updated information regarding this test which had been commissioned by the department store but this had not been made available to them as yet.

We saw that records were kept to demonstrate that medicines were stored in the fridge at the required temperature of between two and eight degrees Celsius. Staff completed and signed records every day.

We were told that this practice dispensed medicines. We saw that a log was kept of prescribed drugs; this was checked on a monthly basis to ensure they were within their expiry date. A log book of dispensed medicines was available. This recorded the patient details along with details of the medicine but the information had not been signed by the prescriber.

There was no hazard warning sign on the door of the room where the emergency oxygen was stored.

Radiography (X-rays)

The practice had a radiography file which contained up to date information. Details of the Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) were available in this file. The RPA and RPS helped to ensure equipment was operated safely and by qualified staff only. Copies of the critical examination packs for each of the X-ray sets along with the maintenance logs were available for review. The maintenance logs were within the current recommended interval of three years. However, the file did not contain any information regarding the Faculty of General Dental Practice guidelines (FGDP) for selection criteria for dental radiography.

We saw that the practice had notified the Health and Safety Executive that they were planning to carry out work with ionising radiation.

Local rules were available in each of the treatment rooms were X-ray machines were located for all staff to reference if needed.

We saw evidence that all of the dentists were up to date with the required continuing professional development on radiation safety.

Patient care records seen did not demonstrate that where X-rays had been taken, they were justified, and reported on every time.

No action

Are services safe?

We were not shown any radiography audits undertaken by dentists working at the practice as recommended by national guidance. Following this inspection the registered manager confirmed that monthly radiography audits would be completed starting immediately.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patient care records that we saw did not provide evidence that dentists were recording the condition of patient's gums using the basic periodontal examination score (BPE) or of the soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). We found that there was no structure to the notes and no evidence of oral health promotion advice given to patients.

Dental records shown to us did not provide evidence that National Institute for Health and Care Excellence (NICE) guidance was used to determine recall intervals for patients. There was no evidence of any criteria in use to determine the recall arrangements for patients. Records shown to us did not provide evidence that risk factors had been documented and discussed with patients.

Records did not demonstrate that the decision to take an X-ray was made according to clinical need and in line with recognised general professional guidelines. Patient dental care records that we saw did not demonstrate that the dentists were following the guidance from the Faculty of General Dental Practice (FGDP) regarding record keeping.

Health promotion & prevention

We discussed oral health and preventative care with the registered manager and dental nurse. We were told that the majority of patients at this practice maintained good oral hygiene. During appointments the dentist and dental nurse explained tooth brushing and interdental cleaning techniques to patients in a way they understood. The practice manager said that there was rarely a need to prescribe high concentration fluoride toothpastes. We were shown patients' dental care records but there was no information to demonstrate that discussions regarding oral health had taken place. There was no documentary evidence to demonstrate that patients were given advice appropriate to their individual needs such as dietary, smoking cessation and alcohol consumption advice.

Staffing

Practice staff included a registered manager, part time practice manager, two part time dentists, a part time dental hygienist, a full time dental nurse and a receptionist.

We discussed staff training. Staff told us that they were encouraged to attend training courses and supported to develop their skills. Staff told us that they had access to on-line training courses. The registered manager was able to access information about training completed by staff on the on-line system. Staff said that they were sent reminder emails when any training was due and they were encouraged to complete all necessary training.

Records showed professional registration with the General Dental Council (GDC) was up to date for all relevant staff.

We saw evidence in staff recruitment files that staff had undertaken various training courses such as safeguarding and mental capacity, decontamination, legionella, environmental maintenance and cleaning, equality and diversity, and basic life support.

The practice manager confirmed that they monitored staff continuing professional development (CPD) to ensure staff met their CPD requirements. CPD is a compulsory requirement of registration as a general dental professional.

Appraisal systems were in place. Staff said that these were held on an annual basis. We saw copies of appraisal records for staff to demonstrate this. We saw that personal development plans were available for staff. The registered manager and practice manager completed induction training for newly employed staff. We also saw that probationary reviews were held on a three and six monthly basis before employment was confirmed.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment. Systems were in place to ensure referrals were received in a timely manner.

Consent to care and treatment

A patient consent policy had been implemented and reference was made to the MCA in this policy.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

No action

Are services effective?

(for example, treatment is effective)

There were no recent examples of patients where a mental capacity assessment or best interest decision was needed. Staff we spoke with were aware of the MCA and the processes involved in obtaining informed consent for an adult.

Dental care records did not demonstrate that treatment options were discussed with patients, or that any risks involved in treatment were recorded. There was no evidence in some patient dental care records that written consent had been obtained. Staff confirmed individual treatment options were discussed with each patient and consent was always obtained.

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We were told that privacy and confidentiality were maintained at all times for patients who used the service. Treatment rooms were situated off the waiting area. We saw that doors were closed at all times when patients were with the hygienist. Conversations between patient and dentist could not be heard from outside the treatment rooms which protected patients' privacy. We were told that treatment room doors were always closed when the room was in use.

Music was played in the department store which could be heard in the waiting area; this was intended to help distract anxious patients and also aid confidentiality as people in the waiting room would be less likely to be able to hear conversations held at the reception desk.

We were told that the treatment room or consultation area would be used to hold confidential discussions with patients if necessary. Discussions regarding costs and treatment would be held in the consultation area which was located away from the reception and waiting area.

Patients' clinical records were stored electronically. Computers were password protected and regularly backed up to secure storage. There was a sufficient amount of staff to ensure that the reception desk was staffed at all times. However, if computers were ever left unattended then they would be locked to ensure confidential details remained secure.

We observed staff were friendly, helpful, discreet and respectful to patients when interacting with them on the telephone and in the reception area. Patients commented that staff were professional, friendly, accommodating and caring.

Involvement in decisions about care and treatment

We spoke with two patients on the day of our inspection. We were told that the practice had provided them with information to enable them to make informed choices about any treatment. However records we were shown did not demonstrate that that the dentists had recorded the information they had provided to patients about their treatment and the options open to them. Patients told us that they were aware of how much a treatment would cost before they proceeded. Posters detailing private costs were on display in the reception area.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided private treatment and an indication of treatment costs was displayed in the waiting area. We were told that treatment options and costs would be discussed in full with patients in the consultation area of the practice before any agreement was reached to proceed with treatment.

Information available on the practice's website included details of the staff team, and the services provided, (including details of any special offers) patients could book a free consultation and contact the practice and request a call back.

We discussed appointment times and scheduling of appointments. We found that on two occasions the practice had booked appointment times that did not appear long enough for the treatment provided.

On the days that there was a dentist working in the practice there were vacant appointment slots to accommodate urgent appointments. If these appointment slots were full, or on days when there was no dentist at the practice, patients could visit a local practice which was part of the same dental practice group.

We were told that patients were able to request to see either the male or female dentist and where a preference was expressed this was recorded on their notes.

Tackling inequity and promoting equality

The practice did not have a hearing induction loop for use by people with hearing impairments. However staff said that alternative methods were used to communicate with hearing impaired patients. We were told that arrangements could be made with an external company to provide assistance with communication via the use of British sign language.

We asked about communication with patients for whom English was not a first language. We were told that all patients could communicate in English sufficiently to make their needs known. Some staff were able to communicate with patients who spoke Urdu or Arabic and a translation service was available for use if required.

The dental practice was located on the ground floor of a department store. Access to the treatment room was via a few small steps. Male, female and disabled toilet facilities were available within the department store.

The registered manager told us that all staff had undertaken on-line equality and diversity training.

Access to the service

The practice was open from 9.30am to 6pm on Monday, Tuesday, Wednesday and Friday and 10.30am to 7pm on Thursday (closed for lunch between 2.30pm to 3pm). The practice was also open on Saturdays from 9.30am to 5pm. A hygienist worked at the practice on a Tuesday and dentists worked on a Monday, Thursday, Friday and Saturday. Emergency appointments were set aside by the dentist on these days; during other days of the week patients in dental pain could visit a nearby practice from the Smilestylist group. This ensured that patients in pain could be seen in a timely manner.

A telephone answering machine informed patients that the practice was closed between 2.30pm to 3pm each day. The telephone answering machine also gave emergency contact details for patients with dental pain when the practice was closed during the evening, weekends and bank holidays.

Patients were able to make appointments over the telephone or in person. The practice website had a contact form, where patients could leave their contact details and a member of staff from the practice would call them back. Patients could make an appointment using the contact form. Patients were sent a text message reminder 24 hours prior to their appointment.

Concerns & complaints

The practice had a complaints' policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. This had been reviewed on an annual basis. Patients were given information on how to make a complaint. We saw that a copy of the complaints policy was on display in the waiting area, the practice leaflet also gave patients brief information on how to make a complaint.

Staff we spoke with were knowledgeable about how to handle a complaint. Staff told us that any complaints received would be sent to the practice manager.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Complainants would be telephoned and offered a meeting at the practice. We saw that detailed information was available regarding complaints received at the practice, investigation and outcomes.

We were told that three complaints had been received within the last 12 months. We saw that these had been responded to in a timely manner.

No action

Are services well-led?

Our findings

Governance arrangements

Systems were in place for monitoring and improving the quality of services provided for patients. Comprehensive risk assessments were in place to mitigate risks to staff, patients and visitors to the practice. These included risk assessments for fire, health and safety display screen equipment, electrical equipment, first aid, legionella and a general practice risk assessment. These helped to ensure that risks were identified, understood and managed appropriately.

The practice had policies and procedures in place to support the management of the service, and these were readily available for staff to reference. These included health and safety, complaints, safeguarding adults and protecting children, whistle blowing and infection control.

Staff had been given a number of policies during their induction to the practice. For example staff had copies of the hand hygiene, confidentiality and health and safety policies as well as various other leaflets and training booklets.

As well as regular scheduled risk assessments, the practice undertook both clinical and non-clinical audits. An audit file had been developed which contained copies of all recent audits competed, these were kept in alphabetical order for ease of access. These included six monthly infection prevention and control audits, audits regarding clinical record, although the sample size seen for this audit was small. We also saw audits regarding patient waiting times. We were not shown any radiography audits and staff were unaware if these had been completed as they were not available in the audit file. Following this inspection the registered manager confirmed that monthly radiography audits would commence immediately.

Leadership, openness and transparency

Staff told us that they worked well as a team, provided support for each other and were praised by the management team for a job well done.

The practice had clear lines of responsibility and accountability. Staff were aware of their roles and responsibilities and were also aware who held lead roles within the practice. The practice manager also worked at another local practice owned by the Smilestylist group. The registered manager also worked between several practices. Staff said that on a day to day basis they would speak with the practice manager or the registered manager to obtain advice and support.

We saw that practice meetings took place on a monthly basis. The registered manager told us that when staff were unable to attend the meeting they were briefed upon the discussions held and asked to read a copy of the minutes which were kept in the staff meeting folder.

Staff told us that the registered manager was approachable and helpful. They said that they were confident to raise issues or concerns and felt that they were listened to and issues were acted upon appropriately.

Learning and improvement

The practice had a structured plan in place to audit quality and safety. We saw that infection control audits were completed on a six monthly basis and the practice had not identified any issues for action at the last audit. Other audits included dental care records and health and safety. We saw that one of the record card audits had a very small sample size of five patients and this audit was ineffective in identifying the shortfalls we identified during this inspection.

Annual appraisal meetings were held and personal development plans available for all staff. Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals need to complete 150 hours over the same period. The registered manager monitored staff training to ensure they were up to date with their CPD requirements and staff said that support was available to enable them to complete training.

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

The practice had systems in place to seek and act on feedback from patients including those who had cause to complain. We saw that there was a suggestions box in the waiting room with satisfaction survey forms for patients to complete. Thank you cards were on display. We were told that patients were able to contact the practice via the website to leave comments or ask questions.

No action

Are services well-led?

We were told that although satisfaction surveys were given to patients on a continual basis; patients were often reluctant to complete these forms. Where surveys were completed the responses were positive.

A staff survey was undertaken February 2016 and we were told that there were no issues identified in the survey. Staff we spoke with told us that they felt supported and involved at the practice.

Staff said that they would speak with the practice manager or another member of the management team if they had any issues they wanted to discuss. We were told that the management team were open and approachable and always available to provide advice and guidance.