Overleigh Orthodontics

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 1 March 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

The practice is situated on the outskirts of Chester city centre and has a waiting/reception room, four treatment areas, a decontamination room, administrative offices and an annexe building housing a further treatment room and patient consultation and waiting areas. The practice has three dentists, three dental therapists, six qualified dental nurses, receptionists, administrator and a practice manager. The practice is a specialist dental surgery providing orthodontic treatment to both adults and children. Orthodontics is specialist dental treatment that corrects irregularities of alignment of the teeth in order to improve position, appearance and function of crooked or abnormally arranged teeth. They provide these services predominately to NHS patients and also to some private patients. The practice receives dental referrals from dental practices all over the North West, Cheshire, Shropshire, The Wirral and North Wales.

The practice is open:

Monday, Tuesday, Thursday and Friday 9am – 1pm and 2pm – 5pm and Wednesday 9am – 1pm 2pm – 6pm.

The principal dentist is the registered manager. 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.

Summary of findings

We received feedback from 35 patients about the service. The 31 CQC comment cards seen and four patients spoken to reflected very positive comments about the staff and the services provided. Patients commented that 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:

- The practice reported and recorded accidents and complaints. They did not have a significant event analysis policy and procedures in place; however were to implement a system soon.
- Staff had received safeguarding training and knew the processes to follow to raise any concerns.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to deal with medical emergencies and emergency medicines and emergency equipment were available.
- Infection prevention and control procedures were in place.
- 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 staff felt valued, involved and worked as a team.
- The practice took into account any comments, concerns or complaints and used these to help them improve.

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

- Review the storage of dental care records to ensure they are stored safely and meet health and safety and fire regulations in accordance with the Department of Health's code of practice for records management (NHS Code of Practice 2006) and other relevant guidance about information security and governance.
- Review the practice's system for the recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and, ensuring that improvements are made as a result.
- Review the storage of clinical waste to ensure it was safe and secure.
- Review the access to the local decontamination unit (LDU).
- Review fire safety training to ensure staff undertake this annually and fire safety drills six monthly.
- Review the protocol for completing accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of verbal references taken and ensuring recruitment checks, including references, are obtained and recorded.
- Review the availability of an interpreter service for patients who do not speak English as their first language.

We also found areas of notable practice:

- Dentists, 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 impression taking.
- All patients had their treatment peer assessed and rated using the orthodontic peer assessment rating (PAR) index. Staff were all trained and calibrated in PAR. (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 or the greater proportion of a practitioner's caseload. This practice quality assured all their patients treatment using the PAR index.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had systems and processes in place to ensure care and treatment was carried out safely. The practice reported and documented accidents and complaints. There was no system in place to report, analyse and learn lessons from significant events. On discussion the practice told us they would implement a system following best practice.

Safety alerts were received by the practice and disseminated to relevant staff for action. There was evidence of action taken in response to safety alerts.

Infection prevention and control procedures were in place and staff had received training in infection control. The local decontamination unit (LDU) was accessible and not locked. Clinical waste was stored where it was potentially accessible to patients and public.

The dental X-ray unit was suitably sited and used by trained staff. Local rules were displayed where X-rays were carried out as required by the 2000 IRMER regulations. Emergency medicines and equipment was suitable and checked for efficiency and to ensure they did not go beyond their expiry dates. Sufficient quantities of equipment were available at the practice and were serviced and maintained at regular intervals.

There were sufficient numbers of well qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults. There was an identified lead at the practice for safeguarding and appropriate policies and procedures in place.

Are services effective?

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 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 consented to. The practice kept detailed dental records of oral health assessments; treatment carried out and monitored outcomes of treatment.

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. The treatment provided for patients was effective, evidence based and focussed on the needs of the individual.

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

Are services caring?

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

Patients were treated with dignity and respect and their privacy maintained. Patients spoke highly of the care and treatment given. We found that treatment was clearly explained and patients were provided with information regarding their treatment and oral health. Staff were highlighted to special needs or medical conditions of patients through a flagging system on the computer which helped them treat patients individually and with care and understanding.

Summary of findings

Patients who were nervous or anxious about attending the dentist were cared for with compassion that helped them feel more at ease.

Are services responsive to people's needs?

We found that 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 and accommodated patients with a disability or lack of mobility. Treatment areas and a disabled accessible toilet were located on the ground floor. There was ramp access to the ground floor.

There was a clear complaints system in place.

Are services well-led?

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

There was an effective leadership structure evident and staff felt well supported by the principal dentist and management. Staff were supported to maintain their professional development and skills. Staff attended documented meetings and had discussions to review aspects of the delivery of dental care and treatment and the management of the practice. Patients and staff were able to feedback compliments and concerns regarding the service.

The practice had governance and risk management structures in place. Clinical audits took place. Health and safety risks had been identified and risk assessments were in place and reviewed.

Overleigh Orthodontics

Detailed findings

Background to this inspection

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

The inspection took place on 1 March 2016 and was conducted by a CQC inspector and a dental specialist advisor.

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.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included any complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members, their qualifications and proof of registration with their professional bodies.

We also reviewed information we held about the practice and found there were no areas of concern. During the inspection we spoke with dentists, a therapist, dental nurses, receptionists and the practice manager. We reviewed policies, procedures and other documents. We reviewed 31 CQC comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice, spoke to four patients on the day of inspection and observed one patient being treated.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had procedures in place to record and report accidents and complaints; however they did not have a formal system for reporting, analysing and learning from significant events or clinical incidents. We discussed an example of a significant event that had occurred. This had been dealt with appropriately and action taken to minimise risk, staff had been involved and involved in feedback. Following discussion we were told they would implement a formal system using best practice in order to report, analyse and learn from such events.

Staff were aware of how to report accidents and were encouraged to bring safety issues to the attention of the dentists. The practice had a no blame culture and policies were in place to support this. The dentists and management had an understanding of their responsibilities under the Duty of Candour. Duty of Candour means that people who use services are told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result. The provider also knows when and how to notify CQC of incidents which cause harm.

We found that patient safety alerts were received by the practice and disseminated to relevant staff. They were held on file and we saw evidence of some documented actions.

Reliable safety systems and processes (including safeguarding)

The practice had local policies and procedures in place for the protection of vulnerable adults and children. There were local safeguarding authority's flow charts and guidance of what to do in the event of concerns regarding child and vulnerable adult abuse and access to the local authority's safeguarding policies and procedures. There was an identified lead for safeguarding to provide support and advice to staff and to oversee safeguarding procedures within the practice. Staff were able to demonstrate that they understood the different forms of abuse and how to raise concerns. Training records showed that all staff had received safeguarding training for both vulnerable adults and children to level two.

During our visit we found that the dental care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. Dental care records were paper and electronic and contained a medical history that was obtained and updated prior to the commencement of dental treatment and at regular intervals of care. The clinical records we saw were all 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.

Computers were password protected and data regularly backed up to secure storage. Screens at reception were not overlooked which ensured patients' confidential information could not be viewed at reception. However historic paper records were not stored safely.

Medical emergencies

The practice had procedures in place for staff to follow in the event of a medical emergency and all staff received basic life support training annually. Staff we spoke with were able to describe how they would deal with medical emergencies.

Emergency medicines and oxygen were available. This was in line with the Resuscitation Council UK and British National Formulary guidelines. The practice had an automated external defibrillator (AED) as part of their equipment. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). AEDs are recommended as standard equipment for use in the event of a medical emergency by the Resuscitation Council UK. We found that medicines and equipment were checked to monitor stock levels, expiry dates and ensure that equipment was in working order. These checks were recorded.

Staff recruitment

The practice had a recruitment policy and procedures in place that were in line with requirements relating to workers. Staff records we reviewed demonstrated that all clinical staff had undertaken a Disclosure and Barring Service (DBS) check. Clinical staff had evidence of registration with their professional body the General Dental Council (GDC) and appropriate indemnity insurance. The GDC is the organisation which regulates dentists and dental care professionals in the United Kingdom. We found that

staff files generally contained the information required relating to workers however there was no documented evidence of references or photographic identification for some of the staff files sampled.

Newly employed staff had a period of induction to familiarise themselves with the way the practice ran, before being allowed to work unsupervised. Staff told us they had received an induction however there was no documented evidence in staff records. Suitable job descriptions and contracts of employment were evident.

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

Monitoring health & safety and responding to risks

A health and safety policy and risk assessments were in place. These identified risks to staff and patients who attended the practice. The risks had been identified and control measures were in place to reduce them. There were also other policies and procedures in place to manage risks at the practice. These included infection prevention and control, COSHH, Legionella and fire safety risk assessment, however the fire risk assessment was out of date and in need of review.

We saw records to demonstrate that fire detection and firefighting equipment such as fire alarms and fire extinguishers were regularly tested. However the practice did not undertake formal fire safety training on a regular basis. A recent fire drill had been carried out and we were assured the practice would undertake and document these every six months.

The practice had a business continuity plan in place. The plan contained information such as emergency contact details and what to do in the event of example situations occurring.

Infection control

The practice was visibly clean, tidy and uncluttered. The practice clinical areas had been furbished to a high standard and the treatment rooms had units, work surfaces and furniture that promoted good infection prevention and control. There was an overarching infection control policy in place and supporting policies and procedures which detailed decontamination and cleaning. General cleaning was undertaken by a cleaner and a cleaning schedule was in place that was monitored and followed National Patient Safety Association (NPSA) guidance on the cleaning of dental premises. Responsibility for cleaning the clinical areas in between patient treatments was identified as a role for the dental nurses and they were able to describe how they undertook this.

There was a lead dental nurse for infection control and decontamination in the practice. Staff had received training in infection prevention and control as part of their continuous professional development. We saw evidence that the practice had undertaken an infection control audit and demonstrated compliance with current Department of Health's guidance, Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05). Plans were in place to carry out this audit every six months as per best practice guidelines.

We found that there were adequate supplies of liquid soaps and paper hand towels throughout the premises. Posters describing proper hand washing techniques were displayed throughout the practice. There was a policy and procedure for dealing with inoculation /sharps injuries. Sharps bins were properly located, signed, dated and not overfilled. The practice had plans in place to implement a safer sharps system in accordance with Health and Safety (sharp instruments in healthcare) Regulations 2013. A clinical waste contract was in place. Clinical waste was not stored securely and was stored in an accessible area to patients and public until collected.

We looked at the procedures in place for the decontamination of used dental instruments. The practice had a dedicated local decontamination unit (LDU). However the LDU was not secure and was accessible to patients and the public. The decontamination room had defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye/face wear.

We found that instruments were being cleaned and sterilised in line with published guidance (HTM 1-05). On the day of our inspection, the lead dental nurse for decontamination demonstrated the decontamination process to us and used the correct procedures. The practice cleaned their instruments manually and with an automatic washer/disinfector. Instruments were then rinsed and examined using an illuminated magnifying glass

Are services safe?

to enable closer inspection of instruments after cleaning. Instruments were then sterilised in a validated autoclave. At the end of the sterilising procedure the instruments were correctly packaged, sealed, stored and dated with an expiry date. We looked at the sealed instruments in the surgeries and found that they all had an expiry date that was within the recommendations of the Department of Health.

The equipment used for cleaning and sterilising was checked, maintained and serviced in line with the manufacturer's instructions. Daily, weekly and monthly records were kept of decontamination cycles to ensure that equipment was functioning properly. Records showed that the equipment was in good working order and being effectively maintained.

Staff were well presented and wore uniforms inside the practice only. We saw and were told by patients that they wore personal protective equipment when treating patients. We saw documented evidence that clinical staff had received inoculations against Hepatitis B. People who are likely to come into contact with blood products and are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.

The practice had a legionella risk assessment and conducted regular cleaning of the dental unit waterlines (DUWL) and regular temperature tests on the sentinel taps in the hot and cold water supplies. A Legionella risk assessment is a report by a competent person giving details as to how to control the risk of the legionella bacterium spreading through water and other systems in the work place.

Equipment and medicines

We found that all of the equipment used in the practice was maintained in accordance with the manufacturer's instructions. This included the equipment used to clean and sterilise the instruments, X-ray sets, dental chairs and all equipment in the treatment rooms. There were processes in place to ensure tests of equipment were carried out appropriately and there were records of service histories for each of the units and equipment tested.

We found that portable appliance testing (PAT) was completed in accordance with good practice guidance. PAT is the name of a process under which electrical appliances are routinely checked for safety.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities. Records of checks carried out were recorded for evidential and audit purposes. Emergency medicines were checked to ensure they did not go beyond their expiry date.

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 noted that 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).This file contained notification to the Health and Safety Executive (HSE) and the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each 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 3 years.

The dental care records we saw showed that dental X-rays were justified, quality assured (graded) and reported on 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 that the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. The dentist monitored the quality of the X-ray images on a regular basis 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, that 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 orthodontics. 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.

The staff we spoke with and evidence we reviewed confirmed that care and treatment was aimed at ensuring each patient was given support to achieve the best outcomes for them. We found from our discussions that staff completed, in line with The National Institute for Health and Care Excellence (NICE) and national orthodontic (BOS) guidelines, assessments and treatment plans and these 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 patient's notes were updated with the proposed treatment after discussing options with the patient. 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 on a regular basis. These included radiographs, treatment planning, medical history taking and record keeping. All patients had their treatment peer assessed and rated using the peer assessment rating (PAR) index. Staff were all trained in PAR. (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 or the greater proportion of a practitioner's caseload. This practice quality assured all their patients treatment using the PAR index.

We reviewed 31 CQC comment cards and spoke to four patients on the day of inspection. Feedback we received reflected that patients were very satisfied with the assessments, explanations and the quality of the treatment. Data from the NHS Dental Services Vital Signs report (December 2015) also concurred with 100% of patients surveyed satisfied with the dentistry they received (compared to a national average of 94% and local area team average of 96%).

Health promotion & prevention

Oral health promotion was part of the practice's philosophy. To facilitate good orthodontic treatment oral hygiene was an important factor. The dentists, therapists and dental nurses all provided oral health advice and education tailored to patients' individual needs. The dental nurses were qualified in oral health and had undertaken specific courses to be able to deliver oral health education.

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

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 DH 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. The sample of dental care records we observed demonstrated that 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 dentists, three dental therapists, six qualified dental nurses, administrative staff, receptionists and a practice manager. Dental staff were appropriately trained and registered with their professional body. The dentists, therapists and dental nurses were appropriately qualified with enhanced skills training in orthodontics. The dentists 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 provided access to update training and training courses. We saw evidence of training courses having taken place such as basic life support and safeguarding, however staff did not receive some core training regularly such as health and safety or fire safety training. Staff we spoke with told us that they were supported in their learning and development and to maintain their professional registration.

Annual staff appraisals and performance reviews took place. Staff told us they would also have informal discussions with the dentists and manager about their performance and any training /development needs. They told us that the practice was supportive and always available for advice and guidance. We saw that the dental nurses were supported to undertake further training relevant to their role such as radiography and impression taking.

Working with other services

The principal dentist explained how they worked with other services. As a specialist treatment centre they took referrals for treatment from across the region. They were also able to refer to other services as needed and liaised with the patient's general dental practitioner in 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 we spoke with on the day of our visit had a clear understanding of patient consent issues. The clinical staff understood the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. We also noted that in instances where treatment plans were more complex the patient was provided with a written statement of the individual findings in language that they could understand.

We saw evidence that patients were presented with treatment options and consent forms and treatment plans were signed by the patient. The dentists and dental nurse explained how they would obtain consent from a patient who suffered with any mental impairment which might mean that were unable to fully understand the implications of their treatment. They explained that they would involve relatives and carers to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005 which provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed that staff at the practice treated patients with dignity and respect and maintained their privacy and confidentiality. Treatment areas were partitioned off and situated away from the main waiting area.

Patients reported they felt that practice staff were kind, helpful and caring and they were treated with dignity and respect at all times. Comments also told us that staff always listened to concerns and provided patients with good advice to make appropriate choices in their treatment.

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 reviewed which told us that they were well cared for when they were nervous or anxious and this helped make the experience better for them.

Involvement in decisions about care and treatment

The dentists explained that patients were given time to think about the treatment options presented to them and made it clear that a patient could withdraw consent at any time. Patients told us that they received a detailed explanation of the type of treatment required, including the risks, benefits and options. Costs (where applicable) were made clear in the treatment plan. We reviewed a number of records which confirmed this approach had taken place.

Patients' comments told us that 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's information leaflet and 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 complaints 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. They also aimed to capture the patient's expectations in relation to their needs and concerns which helped direct staff to provide the most effective form of treatment. Staff were highlighted to special needs or medical conditions of patients through a flagging system on the computer which helped them treat patients individually and with care and understanding.

Tackling inequity and promoting equality

The practice had good facilities and was accessible to patients with reduced mobility and those using wheelchairs. Treatment areas and a disabled accessible toilet were located on the ground floor with a ramp access to this area. The practice currently did not have access to translation services for those patients whose first language was not English.

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. The practice had responded to concerns raised regarding access to therapists later on in the afternoon. Therapists had worked until 4pm however after reviewing comments and complaints therapists are now available for appointments until 5pm.

Patients we spoke with and comments we received told us that there were no concerns regarding waiting times and that appointments usually ran on time. Patients commented that they had sufficient time during their appointment for discussions about their care and treatment and for planned treatments to take place.

Concerns & complaints

The practice had a complaint policy and procedure that explained to patients the process to follow, the timescales involved for investigation and the person responsible for handling the issue. It also included the details of external organisations that a complainant could contact should they remain dissatisfied with the outcome of their complaint or feel that their concerns were not treated fairly. Staff we spoke with were aware of the procedure to follow if they received a complaint.

From information received prior to the inspection we saw that there had been five complaints received in the last 12 months. We found these had been documented and responded to appropriately.

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.

The practice carried out regular audit cycles. These included for example, treatment planning, medical history taking, radiographs and record keeping. Audits were completed on a regular basis and re audits were evident that demonstrated improved outcomes. Treatment outcomes were peer assessed and rated using the peer assessment rating (PAR) index. Staff were all trained in PAR. The practice quality assured all their patients treatment using the PAR index which demonstrated good practice and it would normally be expected to sample peer assess patients for each clinician.

Health and safety risk assessments were in place to help ensure that patients received safe and appropriate treatments. However the fire risk assessment was in need of updating.

There was a range of policies and procedures in use at the practice. These included health and safety, safeguarding children and vulnerable adults, infection prevention control, consent and treatment and human resources. Staff were aware of the policies and they were readily available for them to access. Staff spoken with were able to discuss many of the policies and this indicated to us that they had read and understood them. The policies were localised to the practice.

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 whom to raise any issues with and told us that the dentists and other staff listened to their concerns and acted appropriately. They told us that there were clear lines of responsibility and accountability within the practice and that they were encouraged to report any safety concerns. We were told that there was a no blame culture at the practice and that 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, development and mentoring. Regular appraisals and development reviews took place.

The practice staff attended training days and sessions. These included basic life support and safeguarding, however some formal core training such as fire safety was not evident. Online training was accessible to staff for their continuing professional development.

The dentists and dental nurses kept themselves up to date with current best practice guidelines for dentistry and in particular orthodontics. 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 appropriately qualified and competent to work in the UK. Staff were encouraged and supported to maintain their continuous professional development as required by the GDC.

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

The practice staff told us that patients could give feedback at any time they visited. They undertook patient satisfaction surveys and had systems in place to review the feedback from patients who had cause to complain. They had implemented the NHS Friends and Family Test (FFT) and regularly reviewed comments from this for improvements to service.

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

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information and feedback through these meetings however significant events and complaints feedback was not always part of the agenda and staff felt it would be beneficial to extend meetings to include governance issues.