

Dr Defkalion Alexakis

You Smile Dental Care

Inspection Report

44 Queen Street Market Rasen Lincolnshire LN8 3EN

Tel: 01673 843290

Website: www.yoursmiledentalcare.co.uk

Date of inspection visit: 10 April 2018 Date of publication: 23/05/2018

Overall summary

We carried out a focused inspection of You Smile Dental Care on 10 April 2018.

The inspection was led by a CQC inspector who had remote access to telephone support from a dental clinical adviser.

We carried out this inspection to follow up concerns we originally identified during a comprehensive inspection at this practice on 21 November 2017. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

At a comprehensive inspection we always ask the following five questions to get to the heart of patients' experiences of care and treatment:

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

When one or more of the five questions is not met we require the service to make improvements and send us an action plan. We then inspect again after a reasonable interval, focusing on the area(s) where improvement was required.

At the previous comprehensive inspection we found the registered provider was providing safe, effective, caring and responsive care in accordance with relevant regulations. We judged the practice was not providing well-led care in accordance with regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read our report of that inspection by selecting the 'all reports' link for You Smile Dental Care on our website www.cqc.org.uk.

We also reviewed aspects of the key questions of safe and effective as we had made recommendations for the provider relating to these key questions. These particularly related to issues concerning the Mental Capacity Act 2005, record keeping and the Equality Act 2010. We noted that improvements had been made.

Our findings were:

Are services well-led?

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

The provider had made improvements to put right the shortfalls and deal with the regulatory breach we found at our inspection on 21 November 2017.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

We asked the following question(s).

Are services well-led?

The provider had made improvements to the management of the service. This included purchasing an automated external defibrillator (AED) and a hand held portable suction device. They had ensured all staff had completed training in the Mental Capacity Act 2005. The practice's consent policy had been updated. The security of dental care records had been improved through the purchase of a new hard drive for the computer. The services of a specialist computer service to back up files and ensure the computer system was working effectively had also been arranged. Dental care records had been audited to ensure they met with the Faculty of General Dental Practice guidelines.

The improvements provided a sound footing for the on-going development of effective governance arrangements at the practice.

No action



Are services well-led?

Our findings

At our inspection on 21 November 2017 we judged it was not providing well led care and told the provider to take action as described in our requirement notice. At the inspection on 12 April 2018 we noted the practice had made the following improvements to meet the requirement notice:

- The provider had reviewed their systems and processes to enable them to monitor risks and to take appropriate action to mitigate risks, relating to the health, safety and welfare of patients and staff. This included ensuring there was a full set of emergency equipment available. A new automated external defibrillator (AED) had been purchased and staff had received instruction in how to use the AED. In addition a hand held portable suction unit had been purchased and added to the emergency equipment in the practice.
- A system to receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) had been established with relevant information shared with all staff members.
- The provider had updated the practice's consent policy to include relevant information related to the Mental Capacity Act 2005 and information relating to Power of Attorney. To accompany this consent forms used in the practice had been reviewed and updated.
- To improve and ensure the security of dental care records a new hard drive for the computer had been purchased. The services of a specialist computer service had been engaged to back up files and ensure the computer system was working effectively.

- The provider had reviewed the information given to patients with regard to the risks and benefits of different dental treatments and procedures. Leaflets had been updated and these were routinely given to patients during their appointment relating to the particular treatment or procedure they were receiving. We reviewed a sample of dental care records and saw that relevant information relating to diet and smoking had been recorded.
- Dental care records had been audited in February 2018 to check they contained the relevant information and followed guidance from the Faculty of General Dental Practice guidelines.

The practice had also made further improvements:

- There had been a review of staff training in relation to the Mental Capacity Act 2005. We saw certificates to evidence that all staff at the practice had completed this training in February 2018.
- The practice had not purchased an induction hearing loop to assist people who had hearing difficulties. This was because the provider was looking into which type or system would be best suited to the premises. The provider said they were committed to getting a hearing loop, but wanted to be sure they got the right one.

These improvements showed the provider had taken action to address the shortfalls we found when we inspected on 21 November 2017.