Dr. Sacha Young

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Inspection Report

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Ratings

Overall rating for this service	No action ✓
Are services safe?	No action ✓
Are services effective?	No action ✓
Are services caring?	No action ✓
Are services responsive?	No action ✓
Are services well-led?	No action ✓

Overall summary

We carried out an announced comprehensive inspection on 12 January 2017 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found 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?

Summary of findings

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

Background

Dr. Sacha Young provides primary dental care services from Fauchard House in the city of Plymouth, Devon. The practice provides NHS dental services. There are currently five active dental surgeries situated over three floors. (The practice has nine surgeries in total but employs five dentists). Approximately 32,500 patients are registered at the practice.

The staff structure of the practice consists of five dentists. There provider/principal dentist also manages the practice. The dentists are supported by a team of dental nurses and receptionists. Most nurses at the practice are trainees. The practice is also a training practice for dentists in their foundation years after graduating.

The practice is open from Monday to Friday from 9.00am to 6.00pm. There is an answer phone message directing patients to emergency contact numbers when the practice is closed.

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.

The inspection took place over one day and was carried out by a CQC inspector.

One hundred patients provided feedback directly to CQC about the service. Ninety nine patients' comments were positive about the care they received from the practice. Patients were complimentary about the friendly, professional and caring attitude of the dental staff and the dental treatment they had received. One patient left mildly critical feedback about the treatment they had received. The principal dentist responded to this feedback by contacting the patient to try and resolve their concerns about the treatment they had received.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- There was a lead staff member for safeguarding patients. All staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from the practice team.
- Patients could access treatment and urgent and emergency care when required.
- Patients could book appointments up to 12 months in advance.
- Appointment phone reminders were available on request 48 hours prior to appointments.
- The provider had a clear vision for the practice and staff told us they were well supported by the principal dentist.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and there was a programme for building maintenance.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Staff received training appropriate to their roles and were supported in their continued professional development by the management team.
- Staff we spoke with felt supported by the management team and were committed to providing a quality service to their patients.

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

Summary of findings

- Review the practice recruitment policy and procedures to ensure background checks and references for new staff are consistently received prior to staff employment.
- Implement a record summarising the outcome of all complaints received and any learning for the staff team taken forward as a result of complaints.
- Maintain a written record of all fire alarm tests.
- Monitor and respond to patient feedback received via the NHS Choices website.

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.

The practice had systems to minimise the risks associated with providing dental services. The practice had policies and protocols, which staff were following, for the management of medical emergencies and infection control. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

Staff had good awareness of safeguarding issues, which were informed by and supported by practice policies. Staff received the recommended training to ensure safeguarding awareness and adherence to practice polices were maintained. Infection control processes were safely managed. Equipment used in the practice was checked for effectiveness; although records of fire alarm tests had not been recorded. Staff recruitment was not consistently robust and the details of our findings are included in this report.

Are services effective?

No action

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, National Institute for Health and Care Excellence (NICE) and from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice.

Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC). New staff had received an induction and were engaged in a probationary process to review their performance and understand their training needs.

Are services caring?

No action

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

We received feedback from 100 patients. The practice also received patient feedback via internal surveys and through the NHS Choices website. Feedback was consistently positive. Patient survey results were complimentary about the practice staff and treatment received. Patient survey results said that the staff were kind and caring and that they were treated with dignity and respect at all times.

We found that dental care records were stored securely and patient confidentiality was well maintained.

Summary of findings

Are services responsive to people's needs?

No action

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

Patients had good access to appointments, including emergency appointments, which were available on the same day.

There was a complaints policy in place. Complaints were addressed in a timely way and resolutions aimed to the satisfaction of the complainant. It was not clear what learning for the staff team had been taken forward as a result of complaints received.

Systems were in place for receiving more general feedback from patients, with a view to improving the quality of the service. This included patient surveys and patient testimonials sent directly to the practice and the use of the NHS Choices website. The practice had a system to publicise responses about what had been done as a result of patient feedback sourced by the practice but not when patient feedback was sent to third party websites.

The facilities were not suitable for people who were wheelchair users due to the age and design of the premises.

Are services well-led?

No action

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

The practice had clinical governance and risk-management structures in place. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the management team. They were confident in the abilities of the managers to address any issues as they arose.

Dr. Sacha Young

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.

We carried out an announced, comprehensive inspection on 12 January 2017. The inspection was led by a CQC inspector who had access to remote advice from a specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with eight members of staff (principal dentist, three trainee dental nurses, one dentist, one vocational training dentist by equivalent, who is a non-EU trained dentist under clinical supervision and two receptionists). We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. A dental nurse demonstrated how they carried out decontamination procedures of dental instruments.

One hundred patients provided feedback about the service. We also looked at written comments about the practice in the practice internal surveys and comments left about patient experiences on-line via NHS Coices. Patients were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff. Patients commented that they were likely to recommend the practice.

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 was a system for reporting and learning from incidents. There had been no significant events related to patients or staff in the past year.

We discussed the investigation of incidents with the principal dentist. They confirmed that if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result. Practice staff were aware of their responsibilities under the Duty of Candour.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

Whole staff team meetings were held regularly with the last staff meeting in December 2016, the next meeting was scheduled for in January 2017. There were daily team briefs before the practice opened. Team meetings were informally recorded. The principal dentist told us they were in the process of revising minutes recording for team meeting to ensure that records of when actions resulting from team meetings were addressed and signed off as closed. We were shown a template of the system that was going to be introduced in January 2017, which would ensure that meeting records were robustly recorded.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the named practice lead for child and adult safeguarding. They were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia, children and patients with mental health problems.

The practice had a safeguarding policy reviewed in the last 12 months. The policy referred to national and local guidance. Information about the local authority contacts for safeguarding concerns was held in a file in the staff room. The staff we spoke with were aware of the location of this information. There was evidence in staff files showing that all staff had been trained in safeguarding adults and children to the recommended level two.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. The practice had a current policy on the re-sheathing of needles, giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff were aware of the contents of this policy. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries. We also saw that where a needle stick injury had occurred that the policy and protocol had been followed.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (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).

Medical emergencies

The practice had arrangements to deal with medical emergencies. The practice had an oxygen cylinder, and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. An automated external defibrillator (AED) was situated in with the emergency equipment in an area accessible only to staff. This was available for the dental practice to use; the staff were aware of its location and how to use it. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff.

Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment. This equipment was checked for safe use each day the practice was open.

No action

Are services safe?

On the day of the inspection we noticed there was no eye wash available for use iin the event of a chemical splash affecting the eyes. We raised this with the principal dentist who took immediate action to source and install an eye wash station for the practice with the first aid equipment.

Staff recruitment

The staff structure of the practice consisted of five dentists and a team of dental nurses and trainee dental nurses and reception staff. The practice was also a training practice for dentists in their foundation years after graduating.

There was a recruitment policy which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications and a check of registration with the General Dental Council.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all dentists prior to employment. We saw evidence that all dentists had a DBS check. (The 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). We looked at two staff files. We asked why the principal dentist did not carry out DBS checks for other staff. They said that they were not aware that these were required. DBS checks for all clinical staff are required and a risk assessment should be completed for non-clinical staff, if a DBS check is not carried out. Immediately following our visit evidence of existing transferrable DBS checks for dental nurses/dental nurse trainees was forwarded to us and the principal dentist wrote to us to say that new DBS checks for all dental nurses/ trainee dental nurses and receptionists had been applied for. The provider also wrote to us to say that other employment background checks, such as where staff files did not have two references, had also been requested. In the two staff files we looked at on the day of the inspection all information was included in the files we viewed.

Monitoring health & safety and responding to risks

There were arrangements to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had considered the risk of fire, had clearly marked exits and an evacuation plan. There were also fire extinguishers situated at suitable points in the premises. The practice carried out fire drills. The last was carried out within the preceding 12 months. The premises fire risk assessment had been reviewed during January 2017. The principal dentist said that the fire alarm was tested but that this was not recorded. We advised the principal dentist that a record of regular testing of the fire alarm system should be maintained. They said that they would arrange for weekly tests of the fire alarm system recording to demonstrate where and when the tests had been carried out.

There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. COSHH products were securely stored.

The practice had a system for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS). Relevant alerts were discussed during staff meetings which facilitated shared learning.

Infection control

There were effective systems to reduce the risk and spread of infection within the practice. There was an infection control policy, which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. The principal dentist arranged for bi-annual audits of infection control processes at the practice using a recognised industry assessment tool. We viewed the most recent audit, carried out during December 2016. As a result further staff training had been arranged for trainee dental nurses on the principles of infection control and minimising cross contamination in the dental practice. Staff training had taken place during November 2016 on the topic of sterilising dental equipment.

We observed that the premises appeared clean, tidy and clutter free. Clear zoning demarked clean from dirty areas in all of the treatment and decontamination rooms. Hand-washing facilities were available in clinical areas, including wall-mounted liquid soap, hand gels and paper towels in each of the treatment and decontamination rooms.

We asked a dental nurse to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice

followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'.

The dental nurse explained the decontamination of the two purpose built decontamination rooms and dental surgeries. The dental nurse described the process they followed to ensure that the working surfaces, dental units and dental chairs were decontaminated. This included the treatment of the dental water lines. Environmental cleaning was carried out in accordance with the national colour coding scheme by the cleaning staff employed to work throughout the building.

We checked the contents of the drawers in one of the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. Each treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

Instruments were manually cleaned in the treatment room then inspected under a light magnification device and then placed in an autoclave (steriliser). When instruments had been sterilised, they were pouched and stored appropriately until required. Pouches were dated with a date of sterilisation and an expiry date in accordance with HTM 01-05.

The practice carried out checks of the autoclave to assure that it was working effectively. Twice daily checks when the practice was open included the automatic control test and steam penetration test. A log book was used to record the essential daily validation checks of the sterilisation cycles.

We noticed that bars of soap were provided in staff toilet areas. We raised this with the principal dentist with regard to best practice for infection control. Immediately following our visit the principal dentist sent us photographic evidence of wall mounted liquid soap dispensers having been installed in toilet areas and bars of soap removed to minimise the risk of cross contamination when hand washing after using toilet facilities.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location within the practice prior to collection by the contractor. Waste consignment notices were available for inspection. Not all clinical waste bins were foot operated as per best practice guidelines. We raised this with the principal dentist who ordered replacement pedal bins for clinical waste during the visit.

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.) Records we looked at confirmed that the relevant staff had the correct level of cover for Hepatitis B.

The dental 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). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had most recently been carried out by an external contractor during 2012 and had been reviewed annually. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. The practice kept a record of the outcome of these checks on a monthly basis.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. Certificates for pressure equipment had been issued in accordance with the Pressure Systems Safety Regulations 2000. Portable appliance testing (PAT) had been completed in accordance with current guidance and was next due during 2018. PAT is the name of a process during which electrical appliances are routinely checked for safety every two years as a minimum.

The expiry dates of medicines, oxygen and equipment were monitored using daily, weekly and monthly check sheets to

No action

Are services safe?

support staff to replace out-of-date medicines and equipment promptly. Dental care products requiring refrigeration were stored in a fridge in line with the manufacturer's guidance.

Radiography (X-rays)

There was a radiation protection file, which was in the process of being completed at the time of the inspection, in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the documentation pertaining to the maintenance of the X-ray equipment. We saw that the X-ray equipment had been serviced within the three yearly recommended maintenance cycle.

We saw evidence that the dentists had completed radiation training in the last 12 months.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. We spoke with three dentists and asked them to describe to us how they carried out their assessments. The assessment began with the patient completing a medical history update covering any health conditions, medicines being taken and any allergies suffered. We saw patients being asked to complete a medical history when they booked in for their appointment to give to the dentist. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. Treatment plans were printed for each patient on request, which included information about the NHS costs involved. Patients were referred to the practice information posters, or website for cost information on routine treatments. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of six dental care records to confirm the findings. These showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums and soft tissues lining the mouth were noted using the basic periodontal examination (BPE) scores. (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). These were carried out, where appropriate, during a dental health assessment.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Dentists told us they discussed oral health with their patients, for example, around effective tooth brushing. They were aware of the need to discuss a general preventive agenda with their patients. They told us they held discussion with their patients, where appropriate, around smoking cessation, sensible alcohol use and diet. The dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials displayed in the reception area. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We checked the staff recruitment files and saw that this was the case. The training covered the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and X-ray training. Staff told us that the principal dentist was supportive and invested in their staff through regular training opportunities to promote clinical excellence at the practice.

There was a written induction programme for new staff to follow and evidence in the staff files that this had been used at the time of their employment.

There had been some recent staff changes at the practice. The practice had a large patient list (approximately 32,500 patients) but was struggling to manage the list size due to dentist vacancies. The principal dentist was in dialogue with NHS England, the commissioning agency, and had an agreement to not accept any new NHS patients. We saw enquiring patients being politely refused acceptance to the practice list during the visit.

Working with other services

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients.

Staff at the practice explained how they worked with other services, when required. The dentists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for complex orthodontic work.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent via an on-line resource to the hospital

No action

Are services effective?

(for example, treatment is effective)

with full details of the dentist's findings and a copy was stored on the practice's records system. Where secondary services did not accept on-line referrals letters were posted. We looked at three examples of referral letters. These were comprehensively completed and referrals took place in a timely way to avoid delay to treatment. The receptionists kept a log book noting the dates when referrals were made, when the appointment had been completed and further actions required for follow up.

Consent to care and treatment

The practice ensured verbal consent was obtained for all care and treatment. Written consent was recorded for complex treatment in the form of treatment plans. We looked at six patients' dental records for routine examinations and treatment (such as scale and polishing). In these records there was no note of patient consent given. We spoke to the principal dentist about recording patient consent. Immediately following the visit they told us they had amended the template for dental records to prompt dentists to record patient consent. They said this would be raised as a training and discussion point at the next scheduled staff team meeting.

All of the staff were aware of the Mental Capacity Act 2005. (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). Records showed all staff had completed formal training in relation to the MCA on induction after joining the practice. The dentists could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, check for appropriate lasting power of attorney authorisation to act on a person's behalf, along with other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received feedback from 100 patients in total. The patient comments cards we received and interviews with patients were positive in their assessments about the staff's caring, professional and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. One person made a mildly negative comment about treatment received. The principal dentist followed this up with the patient to try and resolve their concerns for future treatment.

We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were having treatment. Conversations between patients and the dentists could not be heard from outside the rooms, which protected patients' privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in a paper format in a dedicated lockable staff only area. There were also electronic records for X-rays and charting. Computers were password protected and regularly backed up. The practice employed a cleaner who attended the practice when patients were not present. They had signed a confidentiality agreement between themselves and the practice for when cleaning in the practice when unsupervised in order to protect the confidential information about patients held at the practice.

Involvement in decisions about care and treatment

The practice detailed information about services on the practice website. This gave details of the range of services available, dental charges or fees. A poster detailing NHS costs was displayed in the waiting area.

We spoke with eight staff on duty on the day of our inspection. All of these staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable.

The patient feedback we received on the day of the inspection confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system to schedule enough time to assess and meet patients' dental needs. The dentists decided on the length of time needed for their patients' consultation and treatment according to patient need. Same day urgent appointments were scheduled for patients registered with the practice. There was high demand for same day urgent assessments. The practice endeavoured to fit all requests for same day treatment in. This could result in patients being double booked and seen as soon as a dentist was available. The receptionists said that patients were told when booking that this could result in waiting times for assessment. The feedback we received from patients indicated that they received assessment and/or treatment on a same day basis when requested and that they had been made aware that they may have to wait to be seen. However, patients said to us they felt their appointments had not felt rushed.

Staff told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one.

During our inspection we looked at examples of information available to people. The practice website contained a variety of information, including opening hours and costs. There were also posters regarding services available in the patient waiting areas.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its service. There was an equality and diversity policy for staff to refer to. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Reception staff showed us they provided written information for people who were hard of hearing and translation services were available for patients speaking English as a second language. Several of the dentists were also multi-lingual. There were both female and male dentists to facilitate requests for same gender examinations or treatment.

The practice was a converted Edwardian town house over several floors. The premises were accessed via steps from the street level. There were ground floor treatment rooms but the building was not suitable for wheelchair users. The principal dentist told us that enquiring patients who used wheelchairs were directed to the local NHS dental access centre which was wheelchair accessible.

Access to the service

The practice opening hours were from Monday to Friday 9.00am to 6.00pm. There was an answer phone message directing patients to emergency contact numbers when the practice closed.

The receptionists told us those patients, who needed to be seen urgently, for example because they were experiencing dental pain, were seen on the same day that they alerted the practice of their concerns. The feedback we received via comment cards confirmed that patients had good access to the dentist in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was displayed in the patient waiting areas. There was a formal complaints policy describing how the practice handled formal and informal complaints from patients. There had been six complaints recorded during the last 12 months regarding dental work or staff attitude. We looked at all the complaints in detail. They were handled in a timely way and resolved to the satisfaction of the patient complaining. However, the practice lacked a record of demonstrating in summary form the outcome of all complaints and/or learning for the staff team as a result of complaints received. We raised this with the principal dentist who told us that they were working on the introduction of a new template to capture this information to demonstrate that their complaints procedures were effective.

Patients were also invited to give feedback through internal surveys and the NHS Friends and Family feedback. There were systems which publicised the action taken by the practice as a result of patient feedback through a notice board in the waiting area. Prior to the visit we looked at patient feedback on the NHS Choices website. We noticed that the practice had not responded to comments left by patients on this website. The principal dentist said they had not been monitoring comments left about the practice on this website. Therefore they could not show that comments about the practice and dental treatment had been taken into account when planning for making improvements

No action

Are services responsive to people's needs?

(for example, to feedback?)

about the practice. The principal dentist told us that they would arrange to register with NHS Choices as a provider of dental services in order to respond to feedback left by patients.

No action

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a management structure. The governance arrangements for this location were overseen by the principal dentist who was responsible for

the day to day running of the practice. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them. There were arrangements for identifying, recording and managing risks through the use of risk assessment processes.

Regular staff meetings took place and the principal dentist was in the process of improving record keeping for staff meetings held. Staff told us that communication within the practice was good.

The principal dentist told us about the governance structures and protocols at the practice. A systematic process of induction and staff training was in place which ensured that staff were aware of, and were following, the governance procedures.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the principal dentist. They felt they were listened to and responded to when they did so.

We found staff were dedicated in their roles and caring towards the patients. We found the dentists provided effective clinical leadership to the dental team.

Staff told us they enjoyed their work and were supported by the principal dentist. Not all dental nurses, trainee dental nurses and receptionists had received a formal appraisal in the last 12 months. However, staff told us that they had received verbal feedback about their performance in the last 12 months when working in clinical supervision with dentists and that they had discussed their individual training needs and wishes with the principal dentist. The principal dentist told us they were working on formalising the appraisal process for all staff and showed us a draft staff appraisal document. They had scheduled appraisals for the whole staff team to take place during 2017.

Learning and improvement

We found there were a number of clinical audits taking place at the practice. These included infection control, clinical record keeping and X-ray quality. There was evidence of repeat audits at appropriate intervals and these reflected standards and improvements were being maintained. For example, twice yearly radiograph, specialist referrals, medical history and infection control.

Staff were being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that the clinical staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC. Training was completed through a variety of resources including the attendance at face to face and online courses. Staff were given time to undertake training which would increase their knowledge of their role.

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

The practice gathered feedback from patients through the use of patient surveys. Actions had been taken as a result. For example, a self-closing devise had been fitted to the front door to prevent drafts uncomfortably affecting the temperature in the patient waiting area. In response to patient feedback about phone lines frequently being busy the principal dentist arranged for the installation of additional phone line capacity at the practice to ease this phone line congestion.

Staff told us that the management team were open to feedback regarding the quality of the care. All staff were aware of the practice whistleblowing policy and felt they could raise concerns, which would be acted upon by the management team.