Care Quality Commission

Rodericks Limited

Revive Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 3 September 2015 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

Revive Dental Practice was registered with the Care Quality Commission (CQC) in July 2011. This was to provide dental services to patients in the Chaddesden area of Derby and the surrounding areas in the county of Derbyshire. The practice provides mostly NHS dental treatment (approximately 95%). The dental practice is owned by Roderick's Limited, a corporate provider with 56 registered locations. Services provided include general dentistry, dental hygiene, cosmetic dentistry and dental implants.

The practice is located on the first floor of a purpose built health centre. Access to the practice is either by stairs or a passenger lift. The practice is open Monday to Friday 8:30 am to 5:30 pm, Tuesdays 8:30 am to 7:00 pm and alternate Saturday mornings 9:00 am to 1:00 pm.

The practice has three dentists, two dental nurses and four trainee dental nurses. All six dental nurses also worked on reception. The practice had a practice manager. One dental nurse was registered with the General Dental Council. One was newly qualified and awaiting their registration documentation and the other four were trainee dental nurses.

A representative of the provider 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

Summary of findings

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

We viewed 10 Care Quality Commission (CQC) comment cards that had been completed by patients, about the services provided. We saw that all 10 comment cards had wholly positive comments. Patients said they received a good service and the staff were friendly, professional and competent. In addition, we spoke with two patients who also said they were happy with the dental service they were receiving. Patients said they were treated well at the practice, and were able to ask questions. Both patients said their dentist explained the treatment options and costs.

Our key findings were:

- The practice had systems and procedures for recording accidents, significant events and complaints. Learning from complaints and significant incidents were recorded and learning was shared with staff.
- The practice had provided training in safeguarding and whistle blowing for all staff during 2015, and staff were aware of these procedures and the actions required.
- The practice had a high turnover of dental nurses due to promotion which had led to inconsistency when working with dentists. This also meant that the majority of dental nurses were quite inexperienced.
- Staff had been trained to deal with medical emergencies.
- There was a strong team ethos, and staff were encouraged to contribute towards training and sharing their knowledge.
- The practice engaged in health promotion initiatives, to encourage patients to have good oral health.
- Emergency medicines and life-saving equipment were readily available.
- There were robust recruitment procedures in place for new staff.
- The practice followed the relevant guidance - Department of Health's guidance, 'Health Technical Memorandum 01-05' (HTM 01-05) for infection control.
- Patients' care and treatment was planned and delivered in line with National Institute for Health and Care Excellence (NICE) guidelines.
- Feedback from patients was positive about the services on offer, and the staff working at the practice.
- Patients were involved in decision making, options were identified and patients had the opportunity to ask questions.
- Patients' confidentiality was maintained.
- The practice sought regular feedback from staff and patients about the services they received.

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

- Stock sufficient quantities of equipment to safely meet patients' needs: -particularly in relation to rubber dam kits.
- Review policies, procedures and risk assessments are all dated to identify that they are current and up-to-date.
- Clearly identify emergency cut-off switches for the X-ray machines in all treatment rooms.

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 procedures for reporting accidents and significant events and learning points were discussed and shared with staff in team meetings.

Staff had been trained in safeguarding vulnerable adults and children, and the training had been updated. There were clear guidelines for reporting safeguarding concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters.

The practice had both procedures and equipment for dealing with medical emergencies. Staff had been trained to deal with medical emergencies and the equipment required.

Robust recruitment checks were completed on new members of staff to ensure they were suitable and appropriately qualified and experienced to carry out their role.

Infection control procedures followed published national guidance to ensure that patients were protected from any potential risks. Staff had been trained to use the equipment in the decontamination process. The equipment was maintained by a reputable company and regular frequent checks were carried out to ensure equipment was working properly and safely.

X-rays were carried out safely in line with published guidance, and X-ray equipment was regularly serviced to make sure it was safe for use.

Are services effective?

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

Patients were assessed before treatment began. This included completing a health questionnaire or updating one for returning patients. Dentists used a recognised national assessment tool to carry out the assessment.

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients.

Dentists discussed the use of alcohol and tobacco and provided dietary advice to help improve patients' oral health.

The practice had sufficient numbers of qualified and experienced staff to meet patients' needs. However a high turnover of dental nurses due to promotion had left the practice with a largely inexperienced team of dental nurses.

There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Referrals were made in a timely way to ensure patients' oral health did not suffer.

Staff were aware of the need for valid consent, and patient records reflected this.

Are services caring?

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

Staff maintained patient confidentiality and worked in a way that protected patients.

Patients were treated with dignity and respect, and staff were open and welcoming to patients at the practice.

Summary of findings

Patients provided positive feedback about the dental care they received, and had confidence in the staff to meet their needs.

Patients said they felt involved in their care, and were able to express their views and opinions.

Are services responsive to people's needs?

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

The practice had an appointments system that was accessible and met patients' needs.

The practice was purpose built and well equipped. The waiting room was spacious and comfortable and this helped patients relax before their treatment.

The practice had level access from street to surgery, with a passenger lift to take people to the practice. Designated disabled car parking was available close to the front door.

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays which were clearly displayed in the waiting room.

The practice had a complaints policy and procedure, and patients' complaints were treated seriously and addressed.

Are services well-led?

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

The practice encouraged learning and development among its staff.

The practice was carrying out regular audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided.

Patients' views and comments were collected at regular intervals and action was taken to make improvements and address issues.

Revive Dental Practice

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 3 September 2015. The inspection team consisted of one Care Quality Commission (CQC) inspector and a dentist specialist advisor.

Before the inspection we reviewed information we held about the provider together with information that we asked them to send to us in advance of the inspection. During our inspection visit, we reviewed a range of policies and procedures and other documents including dental care records. We spoke with four members of staff, including members of the management team.

Prior to the inspection we asked the practice to send us information which we reviewed. This included the 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 the information we held about the practice and found there were no areas of concern.

During the inspection we spoke with two dentists, the practice manager and two dental nurses. We reviewed policies, procedures and other documents. We reviewed 10 CQC comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice. We also spoke with two patients.

We informed stakeholders, for example NHS England area team and Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had procedures for investigating, responding and learning from accidents, significant events and complaints. Documentation showed the last recorded accident had occurred in June 2015. There had been two recorded accidents in the previous twelve months. Both accidents had involved a member of staff, and had prompted a raising of awareness among the staff. We saw documentation that showed the practice was aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). The practice manager said that there had been no RIDDOR notifications made. We saw the minutes of staff meetings which showed that health and safety matters had been discussed, and learning points shared.

In respect of significant incidents, discussions with the registered manager identified they understood the concepts of reporting and learning from those incidents. We saw evidence that significant incidents were discussed in staff meetings and the learning was shared with other practices within the company where appropriate.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) and informed health care establishments of any problems with medicines or healthcare equipment. The registered manager explained how the alerts were received and information was shared with staff if and when relevant. Information was shared across all practices within the company, and the registered manager took the lead in sharing information. Recent examples had been information about E cigarettes and a possible risk of explosion from battery chargers. This information had been shared with all staff members.

Reliable safety systems and processes (including safeguarding)

The practice had a health and safety law poster on display in the staff room. Employers are required by law (Health and safety at work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

The practice had a safeguarding policy which was dated 2013. The policy included details of how to respond to any concerns and how to escalate those concerns. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. There was an identified lead for safeguarding in the practice who had received enhanced training in child protection to support them in fulfilling that role. All staff at the practice had undertaken training in safeguarding adults and children having completed the training during August 2015.

The practice had a policy and procedure to assess risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. Chemicals were stored in secure area within the practice. As a result the practice had identified potentially hazardous substances that it used. Each substance was identified and risk assessed. Steps to reduce the risks included the use of personal protective equipment for staff and patients and safe and secure storage of hazardous materials. The practice had data sheets from the manufacturer on file to inform staff what action to take if an accident occurred for example in the event of any spillage or a chemical being accidentally swallowed.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 8 November 2015. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

Discussions with dentists and examination of patients' notes identified the dentists were using a rubber dam when completing root canal treatments in line with best practice guidelines from the British Endodontic Society. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth during treatment. However, we saw that the practice only had one rubber dam kit which was shared between dentists. With the need to sterilize the kit between patients this could lead to delays in treatment. This would also prevent treatment that required a rubber dam being carried out on two different patients at the same time. This would also reduce the stress on dentists and dental nurses.

Medical emergencies

There was a medical emergencies policy which had been updated in 2014. The policy made reference to the

Are services safe?

Resuscitation Council UK guidelines. There were also emergency medicines and oxygen to support staff in dealing with any medical emergencies. The medicines were as recommended by the 'British National Formulary' (BNF). We checked the medicines and found them all to be in date. We saw the practice had a system in place for checking and recording expiry dates of medicines. The practice also had a refrigerator for storing medicines and supplies that needed to be at a required temperature. Staff were routinely checking and recording the temperature of the refrigerator to check it was working correctly.

There was an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. All emergency equipment and medicines were stored centrally with all staff being able to access them if required. Records showed all staff had completed basic life support and resuscitation training on 12 June 2015. The training included the use of the practice's AED. The practice manager said this training was updated annually for all staff.

Having the emergency medicines, AED and oxygen available when required met with the Resuscitation Council UK guidelines.

Staff recruitment

We looked at the personnel files for five staff members to check that robust recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff personnel files. This includes: a recent photograph; proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed).

We found that the practice recruitment policy and the regulations had been followed.

A review of documentation showed the practice had an induction system; this was personalised for each new staff member dependant on their job role.

We saw that there had been a number of dental nurses leaving the practice in a relatively short period of time. The practice manager explained that many of the dental nurses had been promoted and moved to other dental practices within the organisation. This had inevitably caused a lack of consistency when working with dentists. The practice was considering allocating a designated dental nurse to each dentist to overcome the problem. A system was in place to ensure that where absences occurred they could be covered, usually by colleagues.

Monitoring health & safety and responding to risks

The practice had a health and safety policy and environmental risk assessments. Both of which had been reviewed during 2015, but neither of which was dated. It is important that policies and risk assessments are dated to identify they are up-to-date and current. Risks to staff and patients had been identified and assessed, and the practice had introduced measures to reduce those risks. For example the practice had a fire evacuation procedure; local rules for the use of X-ray machines were available and a legionella risk assessment had been completed.

The practice also had other specific policies and procedures to manage other identified risks. For example: An infection prevention and control policy, which had been reviewed and updated in March 2015. Processes were in place to monitor and reduce these risks so that staff and patients were safe. The practice had three different types of sharps boxes. One for general sharps, one for medicines and one for cytotoxic medicines (used with patients who were being treated for cancer). Staff told us that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested, and records in respect of these checks had been completed.

Infection control

Infection control within dental practices must follow the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' This document sets out clear guidance on the procedures that should be followed; records that should be kept; staff training; and equipment that should be available. Following HTM 01-05 would comply with best practice.

The practice had an infection control policy which had been reviewed in March 2015. The policy described how cleaning was completed at the premises including the

surgeries and the general areas of the practice. The policy directed staff to complete certain tasks and identified what was required. The practice employed contract cleaners to clean the public areas of the practice such as the waiting room and reception area. Dental nurses had set responsibilities for cleaning and infection control in each individual surgery. The practice had systems for testing and auditing the infection control procedures.

The practice routinely carried out infection control audits on a six monthly basis. We saw copies of audits dated January 2015 and August 2015. The practice scored 100% on both audits and therefore no further action was required from either audit.

The practice used sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) The bins were located out of reach of small children. The health and safety executive (HSE) had issued guidance: 'Health and safety (sharp instruments in healthcare) regulations 2013.' We found that the management of sharps within the practice followed this guidance.

The practice had a clinical waste contract, and waste matter was collected on a two weekly basis. Clinical waste was stored securely while awaiting collection. The clinical waste contract also covered the collection of amalgam (dental fillings) which contained mercury and was therefore considered a hazardous material.

The practice had a dedicated decontamination room that had been organised in line with HTM 01-05. The decontamination room had defined dirty and clean areas to reduce the risk of cross contamination and infection. There was a clear flow of instruments through the dirty to the clean area. Staff wore personal protective equipment during the process to protect themselves from injury. These included heavy duty gloves, aprons and protective eye wear.

We found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). A dental nurse demonstrated the decontamination process, and we saw the procedures used followed the practice policy. Guidance and instructions were on display for reference. The instruments were cleaned using a washer disinfector (a machine similar to a domestic dish washer specifically designed to clean dental instruments. After the washer disinfector Instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in an autoclave (a device for sterilising dental and medical instruments).

The practice had one steam autoclave in use. This was designed to sterilise non wrapped or solid instruments. At the completion of the sterilising process, instruments were dried, packaged, sealed, stored and dated with a date of sterilisation and an expiry date. The practice had a second autoclave but this was not in use as the maintenance contract had expired. The practice had taken steps to reinstate the service agreement, so that the autoclave could be used. We looked at a random sample of sealed instruments in the treatment rooms and found them to be sealed and dated.

We checked the equipment used for cleaning and sterilising was maintained and serviced regularly in accordance with the manufacturer's instructions. There were daily, weekly and monthly records to demonstrate the decontamination processes to ensure that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

Staff said they wore personal protective equipment when cleaning instruments and treating patients who used the service. Our observations confirmed this.

Staff files showed that staff had received inoculations against Hepatitis B and received regular blood tests to check the effectiveness of that inoculation. People (staff) 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 the risk of contracting blood borne infections. A needle stick injury is a puncture wound similar to one received by pricking with a needle.

Records showed a risk assessment process for Legionella had been updated in April 2015. This was to ensure the risks of Legionella bacteria developing in water systems had been identified and measures taken to reduce the risk of patients and staff developing Legionnaires' disease. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The records showed the practice was flushing their water lines in the treatment rooms. Records showed waterlines were flushed for two minutes at the beginning and end of each session,

Are services safe?

and for 30 seconds between patients. This was in keeping with HTM 01-05 guidelines. These measures would reduce the risk of Legionella or any other harmful bacteria from developing in the water systems.

Equipment and medicines

The practice records showed that equipment was maintained and serviced in line with manufacturer's guidelines. Portable appliance testing (PAT) took place on electrical equipment. With the last PAT tests having been completed in December 2012. The practice manager said that PAT testing was due to be completed, and an appointment had been made to renew the PAT tests. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures. Records showed the fire extinguishers had been serviced annually with the last service in August 2015.

Medicines used at the practice were stored and disposed of in line with published guidance. There were sufficient stocks available for use. Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Emergency medicines, oxygen and an automated external defibrillator (AED) were available, and located centrally and securely for use in an emergency. An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

Radiography (X-rays)

X-ray equipment was located in each treatment room. X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were displayed in each area where X-rays were carried out.

The practice had three intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). Each room where an X-ray machine was located had a sign on the door indicating that X-ray equipment was located inside. However the emergency cut-off switches for the X-ray equipment were not clearly labelled. This could cause a delay if the X-ray equipment malfunctioned.

The practice had a radiation protection file which contained documentation to demonstrate the X-ray equipment had been maintained at the intervals recommended by the manufacturer. Records showed that the dates X-ray equipment was tested, serviced and if necessary repaired.

The local rules identified the practice had radiation protection supervisors (the dentists) and a radiation protection agency, as identified in the Ionising Radiation Regulations 1999 (IRR 99). Their role was to ensure the equipment was operated safely and by qualified staff only. Staff members authorised to carry out X-ray procedures were clearly identified. The measures in place protected people who required X-rays to be taken as part of their treatment.

We discussed the use of X-rays with a dentist. This identified the practice monitored the quality of its X-ray images and we saw records to demonstrate this. As a result the practice was able to determine the X-rays were of the required standard. Patients completed medical history forms and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. Patients' notes showed that information related to X-rays was recorded in line with current guidance from the Faculty of General Dental Practice (UK) (FGDP-UK). This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice assessed each patient at the start of their consultation. The assessment included the use of the Basic Periodontal Examination (BPE). The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums. Medical histories included any health conditions, current medicines being taken and whether the patient had any allergies. For returning patients the medical history focussed on any changes to their medical status.

We spoke with one dentist, and one dental nurse who said that each individual patient had their diagnosis discussed with them. Treatment options and costs were explained before treatment started. Discussions with two patients also identified that options and costs were discussed before treatment began. Where relevant, information about preventing dental decay was given to improve the outcome for the patient. The patient notes were updated to reflect the discussion about the proposed treatment and options. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

Discussions with one dentist showed they were aware of NICE guidelines, particularly in respect of recalls of patients, anti-biotic prescribing and wisdom tooth removal. These being the most current guidelines being followed. A review of the records identified that the dentist were following NICE guidelines in their treatment of patients.

Public Health England had produced an updated document in 2014: 'Delivering better oral health: an evidence based toolkit for prevention'. Following the guidance within this document would be evidence of up to date thinking in relation to oral healthcare. Discussions with dentists showed they were aware of the 'Delivering better oral health 'document and used it in their practice.

We reviewed 10 Care Quality Commission (CQC) comment cards. All 10 contained positive comments. Patients said they were very with the treatment they received at the dental practice. Comment cards identified dental staff kept patients informed, and they were able to ask questions.

Health promotion & prevention

There were posters and a range of literature in the waiting room about the services offered at the practice. The practice manager said the practice would be promoting 'Smiles week' at the end of September. A pack containing posters, stickers and stories for children about good dental hygiene had been ordered.

Staff said that patients and particularly children were given advice on tooth brushing, and the use of Fluoride. Work with children included the use of disclosing tablets to highlight plaque, and discussions on good foods and bad foods for your teeth. Children aged 3 to 18 years were provided with a fluoride varnish.

We saw examples in patients' notes that showed patients had received advice on smoking cessation, alcohol and the effect of diet on their oral health. With regard to smoking dentists had highlighted the risks of oral cancer and periodontal disease. Patients' alcohol consumption was recorded (number of units of alcohol per week) as this could affect oral health. However, further discussion would be based on risk for each patient.

Staffing

The practice had three dentists, six dental nurses who also worked on reception and one practice manager.

Prior to the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff who were registered were up to date with their professional registration with the GDC. However, only one dental nurse was registered with the General Dental Council. The other five were either newly qualified and awaiting their registration documentation or were still in training.

We reviewed staff training records and saw staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. CPD is a compulsory requirement of registration with the General Dental Council (GDC). The training records showed how many hours training staff had undertaken together with training certificates for courses attended.

The practice appraised the performance of its staff with annual appraisals. We saw evidence in staff personal files that appraisals had been taking place. We spoke with two members of staff who said they had an annual appraisal with the practice manager.

Working with other services

Are services effective?

(for example, treatment is effective)

The practice had systems in place to refer patients to other practices or specialists if the treatment required was not provided by the practice. For example we saw a referral for a patient to have their wisdom teeth removed under general anaesthetic. The records at the practice showed that referrals were made in a timely way, and followed the protocols and procedures in place at the practice. After treatment the practice monitored patients to ensure they had received satisfactory treatment and had the necessary after care required at the practice.

Patients being referred for oral surgery would usually be referred to the Royal Derby Hospital, although other options such as the Nottingham Hospital (Queens Medical Centre) were available. We saw examples of urgent two week referrals, when there were suspected cancer for example. This was in line with the National Institute for Health and Care Excellence (NICE) guidelines.

Consent to care and treatment

The practice had a policy for consent to care and treatment. For both NHS and private patients consent was recorded on the standard NHS FP17 DC Personal dental Treatment Plan form. This form also detailed the patients' treatment options. The patient signed this form to signify their consent with the agreed treatment. Discussions with dentists showed they were aware of and understood the use of Gillick competency in young persons. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own medical treatment without the need for parental permission or knowledge. The consent policy provided information about Gillick competencies.

The consent policy also had a description of competence or capacity and how this affected valid consent. The policy linked this to the Mental Capacity Act 2005 (MCA). Staff training records showed staff had attended training with regard to the MCA 2005. The MCA 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 how patients were treated by the staff, and whether this was with dignity and respect. The reception desk was an open desk, and conversations could be easily heard in the waiting room. Reception staff told us that they were aware of the need for confidentiality when conversations were held in the reception area, particularly when other patients were present. They said that an unused treatment room was available to discuss matters in private.

We observed a number of patients being spoken with at the reception desk and found that confidentiality was being maintained. We saw that patient records, both paper and electronic were held securely either under lock and key or password protected on the computer.

We viewed 10 Care quality Commission (CQC) comment cards that had been completed by patients. All 10 had positive comments about the staff and the services provided. We also spoke with two patients who said they were very happy with the service and had only positive comments to make. Three comment cards and two patients in person said the staff treated patients with dignity and respect.

Staff and patients told us all consultations and treatments were carried out in the privacy of a surgery and we observed this to be the case. We observed the treatment room door was closed during consultations and that conversations taking place in these rooms could not be overheard.

Involvement in decisions about care and treatment

We spoke with two patients during our inspection. Both made positive comments about the dental practice, and particularly about the dentists they saw. Both said they said they were totally satisfied with the dental treatment they received. The patients spoke positively about all of the staff, and said they had never felt the need to complain. Both patients said that treatment was explained clearly to them including the cost at the start of any treatment. They also said they felt involved in all decisions taken, and were able to ask questions and discuss with the dentists the various treatment options.

CQC comment cards completed by patients were all positive and included comments about how welcoming the staff were, and how patients felt relaxed and at ease.

The practice website clearly described the range of services offered to patients; this included the costs both for NHS and private patients. The practice leaflet and the practice website both carried information about the complaints procedure. The practice also clearly displayed information about the costs of treatment within the waiting room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had an appointment system which patients said met their needs. Where treatment was urgent patients would be seen the same day if possible. The practice leaflet gave details of the arrangements for urgent treatment.

Many of the patients seen at the practice were people of working age and older people. To accommodate the needs of these patients the practice opened late on a Tuesday until 7:00 pm, and alternate Saturday mornings from 9:00 am to 1:00 pm.

New patients were asked to complete a medical and dental health questionnaire. This allowed the practice to gather important information about the patient's previous dental and medical history.

The practice was modern and well equipped, with a spacious waiting room, which staff said helped patients relax before their treatment.

Tackling inequity and promoting equality

The practice had considered the needs of patients who may have difficulty accessing services due to mobility or physical issues. The practice was situated on the first floor with access via either a passenger lift or stairs. The passenger lift allowed step free access from the street to the treatment rooms. This would assist patients with mobility issues, using wheelchairs or mobility scooters and parents with prams or pushchairs. The practice had an assisted toilet, which was accessible for patients.

The practice could be accessed by public transport. Car parking was either street parking or in the practice's car park. This included two parking spaces for disabled patients to park at the side of the practice close to the front door.

Staff members told us that longer appointment times were available for patients who required extra time or support, such as patients who were particularly nervous or anxious.

Access to the service

The practice was located on the first floor of a purpose built health centre. Access to the practice was either by stairs or a passenger lift. The practice was open Monday to Friday 8:30 am to 5:30 pm, Tuesdays 8:30 am to 7:00 pm and alternate Saturday mornings 9:00 am to 1:00 pm. This allowed patients who were working or in full time education to access the dental services outside of their working hours or study time.

There were disabled parking spaces close to the front door which was an automatic powered door for ease of access.

The arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays were clearly displayed in the practice leaflet. Access for urgent treatment outside of opening hours was usually through the NHS 111 telephone line.

Concerns & complaints

Revive Dental Practice had a complaints procedure that explained the process to follow when making a complaint. The timescales and the person responsible for handling the complaint were also identified. Details of how to raise complaints were displayed in the waiting room and on the practice website. The procedure provided the contact details of other agencies the complainant could contact such as the Independent Complaints Advocacy Service (ICAS). Staff said they were aware of the procedure to follow if they received a complaint.

From information received prior to the inspection we saw that one complaint had been received in the previous 12 months. The records of the complaint showed there was an outcome and where appropriate learning for the individual clinician or the practice as a whole. The documentation identified the practice had followed its own policy with regard to timescales, written responses and review.

Care Quality Commission (CQC) comment cards reflected that patients were happy and satisfied with the dental services provided.

Are services well-led?

Our findings

Governance arrangements

The practice monitored and improved the service provided for patients. For example the practice

reviewed feedback from patients, and held regular monthly staff meetings where improvements were discussed. The practice had governance arrangements in place. This was demonstrated by several audits which we reviewed. For example: We saw an audit of X-rays at the practice had been completed in October 2014. We also saw a record keeping audit dated September 2015, this audit followed on from an earlier audit in February 2014 and an action plan dated July 2014. Both recent audits identified that the practice was meeting the needs of its patients.

Risk assessments had also been reviewed, and the practice was well organised with specific files containing information, policies and audits. Discussions with staff identified they were aware of their roles and responsibilities within the practice.

We saw that most policies and procedures were kept under review. However for some policies dates were missing from the documents. As a result we could not say how up-to-date those policies were. We discussed this with the practice manager and the registered manager who agreed to review all policies and procedures to check that they were appropriately dated.

Leadership, openness and transparency

The practice stated in its Statement of Purpose its aim was: "To provide a high quality and range of dental services to the whole community. While providing a friendly and professional service." Discussions with individual staff members identified they were aware of these aims and were working towards them.

Staff told us that they could speak with the practice manager, the area manager or a dentist if they had any concerns. There was a team approach, and staff said they were well supported and knew what their role and responsibilities were.

Responses to patients concerns or complaints had been recorded, and showed an open approach. We saw an example of correspondence to a patient where the practice had apologised for any distress or concern caused.

Staff were aware of how to raise concerns about their place of work under whistle blowing legislation. We saw that the practice had a whistle blowing policy, and all staff had access to the policy.

Learning and improvement

The practice had a culture of promoting learning, development and improvement. Individual staff members had delivered presentations to the rest of the staff team at meetings around different topics. For example safeguarding and the Mental Capacity Act (2005). The practice also held lunch and learn sessions where staff discussed topics related to dental practice.

Until shortly before the inspection the practice had been a training practice for foundation dentists. Foundation dentists are qualified dentists who are required to spend one year after qualification in a supervised role, to gain experience. The dentist responsible for supervising the foundation dentists had left the practice in August 2015. As a result there was no longer an experienced dentist to fill the necessary supervisory role.

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

We saw documentation to demonstrate the practice surveyed its patients on an annual basis. The latest survey having been completed in June 2015. The patients' survey was organised in two ways. An annual focussed survey targeted at 40 patients per dentist. In addition the practice website had a feedback page where patients could give on-going feedback. This included tick boxes to gather basic information and text boxes where patients could express their views and opinions.

Staff said that patients could give feedback any time they visited. The practice participated in the NHS Friends and family test, with a box situated on the reception desk and comment cards available for patients to complete. Patient's responses were analysed on a monthly basis, and displayed in the waiting room. Patients could also comment directly onto the NHS Choices website. We saw that five patient comments had been recorded in this way, all five providing positive feedback.

We saw evidence that information from patients surveys had been discussed in a staff meeting (June 2015) and staff had the opportunity to comment and make suggestions.

Are services well-led?

The practice analysed the complaints it had received, and was able to demonstrate learning from complaints. Information was shared at staff meetings.